SOCIAL SECURITY DISABILITY INSURANCE PROGRAM

HEARING

BEFORE THE

COMMITTEE ON FINANCE
UNITED STATES SENATE

NINETY-SEVENTH CONGRESS

SECOND SESSION

AUGUST 18, 1982

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SOCIAL SECURITY DISABILITY INSURANCE PROGRAM

WEDNESDAY, AUGUST 18, 1982

U.S. SENATE,
COMMITTEE ON FINANCE,
Washington, D.C.

The committee met, pursuant to notice, at 2:03 p.m. in room 2221, Dirksen Senate Office Building, Hon. William L. Armstrong presiding.

Present: Senators Armstrong, Durenberger, Dole, Roth, Chafee, Heinz, Grassley, and Mitchell.

[The press releases announcing the hearing, background material on the social security disability insurance program, and the opening statements of Senators Armstrong and Dole follow:]

[Press Release]

FINANCE COMMITTEE SETS OVERSIGHT HEARING ON SOCIAL SECURITY DISABILITY INSURANCE PROGRAM

Senator Robert J. Dole, Chairman of the Senate Finance Committee, announced today that the committee will hold an oversight hearing on Thursday, August 5, 1982, on the social security disability insurance program.

The hearing will begin at 9:30 a.m. in room 2221 of the Dirksen Senate Office Building.

A representative of the Administration, accompanied by Rhoda Greenberg, Director of the Office of Disability Policies and Lewis Hays, Associate Commissioner of the Office of Hearings and Appeals of the Social Security Administration, and a representative of the General Accounting Office will be the initial witnesses appearing before the committee.

In announcing the hearing, Senator Dole noted "during the 1970's, we in Congress became alarmed at the rapid growth of the disability insurance program. Costs were far outstripping earlier projections and deficits became chronic. Many were concerned that lax administration was at fault—allowing ineligibles onto the rolls and failing to weed out the ones that were already there."

"We amended the law in the Disability Amendments of 1980 to strengthen the administration of the program and insure that people receiving benefits are in fact disabled," Senator Dole said. "Among other important changes, the Social Security Administration is now required by law to review the continuing eligibility of disability cases every 3 years."

"The periodic review of the continuing eligibility of beneficiaries," Senator Dole continued, "has led to confusion and understandable concern on the part of people now receiving disability benefits. These hearings will provide a valuable opportunity to examine how the periodic reviews are proceeding and, more generally, to assess the overall operations of the disability determination process since the enactment of the 1980 amendments."

[Press Release]

FINANCE COMMITTEE POSTPONES OVERSIGHT HEARING ON SOCIAL SECURITY DISABILITY INSURANCE PROGRAM

Senator Bob Dole, Chairman of the Senate Committee on Finance, announced today that the Committee would postpone the hearing scheduled for Thursday, August 5, on the social security disability insurance program. Scheduling conflicts with the House-Senate conference on the Tax Equity and Fiscal Responsibility Act of 1982 will prevent the hearing from being held as previously scheduled. Recognizing the importance of the hearing, Chairman Dole stated that he would postpone the hearing to a date as yet to be determined.

[Press Release]

FINANCE COMMITTEE RESCHEDULES OVERSIGHT HEARING ON SOCIAL SECURITY DISABILITY INSURANCE PROGRAM

Senator Robert J. Dole, Chairman of the Senate Finance Committee, announced today that the hearing on the social security disability insurance program has been rescheduled for Wednesday, August 18, 1982.

The hearing will begin at 2:00 p.m. in Room 2221 of the Dirksen Senate Office Building.

STATEMENT BY SENATOR DOLE FOR SOCIAL SECURITY DISABILITY INSURANCE HEARING

The subject of our hearing this afternoon is the operation of the social security disability insurance program and, in particular, the problems and prospects of the continuing disability investigation (CDI) process. This is an extremely important hearing and I appreciate the many witnesses who have agreed to testify before the committee. As you are probably aware, we have had some difficulty scheduling the hearing. It was through no lack of interest or concern on my part or on the part of Bill Armstrong, but simply scheduling conflicts with the tax bill now before Congress.

At the outset, I would like to thank Senator Armstrong for agreeing to chair the hearing and I understand Senator Heinz will also help chair later in the day. Also, I would like to acknowledge the concern expressed by Senators Cohen and Levin over the operation of the CDI process. Their interest, along with the interest of a number of my colleagues on the Finance Committee, helped prompt this hearing.

To put the hearing into perspective, I think it is important to recall the impetus behind the 1980 Disability Amendments and the requirement that beneficiaries be periodically reviewed. Rapid and unexplained growth in the CDI program in the 1970's led to concern about lax administration and poor incentives for beneficiaries to return to work. Between 1970–1980, DI expenditures increased 5-fold. The number of beneficiaries nearly doubled between 1970–77, alone. The program was chronically underfinanced.

Congress responded by enacting the 1980 amendments, signed by President Carter on June 9, 1980. The amendment of crucial importance today is the one which mandated that, beginning in 1982, all disabled beneficiaries must be reviewed once every three years to determine their continuing eligibility for benefits. According to the Social Security Administration and GAO, as many as 20 percent of the people now on the rolls may not be "disabled" within the strict meaning of the law.

By now, the reviews have been taking place for nearly a year and a half. 310,000 cases were sent to State agencies for review in fiscal year 1981; another 500,000 cases will have been sent by the end of fiscal year 1982. On average, about 54 percent of the people reviewed are having benefits terminated. Upon appeal, Administrative Law Judges are reversing the termination decisions 60 to 65 percent of the time.

This is clearly a difficult situation. Some States are feeling hard-pressed to meet the workload demands of the stepped-up review. People who have been on the rolls for many years—having never been re-examined—are now coming up for review and having benefits terminated. Many people are confused about the process and the importance of providing sound medical evidence on their condition. Significant discrepancies between State agencies—responsible for performing CDI's and determining eligibility—and the ALJs is causing great concern about the reliability and fairness of the disability determination process.

There are now easy or obvious solutions to these problems, however. the Pickle-Archer bill (H.R. 6181) was marked up last March, and was reported out of the Ways and Means Committee on May 26. It hasn't yet made it to the House floor. Opinions vary widely and in all these months a consensus has not been reached.

The current controversy over the removal of disabled beneficiaries from the rolls warrants very careful consideration. A "quick fix" on the floor of the Senate could result in further unforeseen difficulties.

I look toward today's testimony and hearing the recommendations of our witnesses on this important subject.

August 17, 1982

BACKGROUND ON SOCIAL SECURITY DISABILITY INSURANCE

Basic Program Facts

The social security disability insurance (DI) program pays monthly cash benefits to 4.4 million beneficiaries. 2.7 million of these are disabled workers; the remainder are spouses and children. The program is financed by a portion of the social security tax (0.825% of the 6.7% tax).

DI outlays in 1981: $17.7 billion
1982: $18.5 billion

average payment for disabled-worker families: $851/month

Eligibility

To be eligible for DI benefits, a worker must be both "fully" and "disability" insured--that is, have credit for having worked in covered employment for a certain period of time. Generally, this is satisfied if the individual has credit for working at least one calandar quarter for each year after 1950, or if later, after the year in which he reaches 21, and prior to the onset of disability, and if he also has 20 quarters of coverage in the immediately preceding 40 quarters. (There are exceptions for younger workers and the blind.) Currently, more than 95 million people are insured in the event of disability.

Under the law, disability is defined as the inability to engage in substantial gainful activity by reason of a medically determinable physical or mental impairment expected to result in death or last at least 12 months. Generally, the worker must be unable to do any kind of work which exists in the national economy, taking into account age, education and work experience.

1980 Disability Amendments

A number of changes to the DI program were made by the Social Security Disability Amendments of 1980 (P.L. 96-265), enacted June 9, 1980. The provisions were directed toward: (1) limiting benefits so that they would not exceed the worker's predisability earnings; (2) increasing the incentives for disabled workers to return to work; and (3)improving the administration of the program to insure that benefits go only to those who are eligible.

Among other important changes designed to improve administration, this legislation required the Secretary of Health and Human Services to:

- Review a proportion (ultimately at least 65 percent) of DI allowances before benefits are paid;
- Review decisions rendered by administrative law judges (ALJ's); and
- Review the continuing eligibility of disabled workers, starting in 1982, at least once every 3 years (except where the disability is considered permanent, in which case review may be less frequent). Under this "continuing disability investigation" (CDI) requirement, a minimum level of review is mandated.

The legislation was prompted, in part, by increasing concern over the great expansion of the program during the 1970's. Between 1970-1980, expenditures for the DI program rose from $3.3 billion to $15.9 billion. The number of disabled-worker beneficiaries nearly doubled between 1970-1977--from 1.5 million to 2.9 million. The number of new benefit awards to workers and their dependents peaked at 1.26 million in 1975. (Awards have since decreased--there were 787,000 in 1981. The total number of people on the rolls has also declined in the last few years.)

Prior to the 1980 amendments, concern was expressed that the rapid growth of the program may have been due to excessively high benefit levels, which discouraged beneficiaries from returning to work, and to inadequate monitoring of the benefit rolls to insure that determinations of disability were valid. On this latter point, it is worth noting that up until the 1980 amendments, there was no established procedure for periodic redetermination of disability for all or even a sizeable proportion of persons receiving disability benefits. The social security claims manual instructed the State agencies on certain kinds of cases that were to be selected for investigation by means of a medical diary procedure. In general, cases were to be "diaried" for medical reexamination only if the impairment was one of 13 specifically listed impairments.

According to GAO, many beneficiaries who should have been scheduled for reexamination (because of a disability that was expected to improve) were not, and many scheduled medical reexaminations were never done. Based on a sample of 1975 DI awards, GAO found that 52 percent of the cases scheduled for medical reexamination were never reexamined.

Whereas in the late 1960's, 10% of all DI beneficiaries were reviewed each year to determine whether they continued to be eligible for benefits, in the first half of the 1970s, only about 4% were investigated annually.

Continuing Disability Investigations (CDIs)

According to a March 1981 GAO report, entitled "More Diligent Followup Needed to Weed Out Ineligible SSA Disability Beneficiaries", SSA was not adequately following up on DI beneficiaries. Evidence compiled by SSA and GAO suggested that the overall inaccuracy rate in the DI program could be as high as 20%, with more than 90% of these cases involving people who are completely ineligible for benefits. GAO reported that as much as $2 billion annually could be going to 584,000 people on the DI rolls who may not have been disabled within the meaning of the law.

In light of these findings and those of internal quality control studies, SSA accelerated the required review of disabled workers, beginning in March of 1981. It is estimated that the new periodic review will save the trust funds $700 million in FY83, $1.0 billion in FY84 and $1.2 billion in FY85.

In FY81, SSA sent 310,000 cases to the State agencies for reexamination; 169,000 cases were reviewed. SSA projects that some 500,000 cases will be sent to States for review in FY82, and that another 806,000 cases will be sent in FY83.

Although allowance rates vary widely among States, recent data indicate that 54% of cases reviewed are being found to continue meeting eligibility requirements. The allowance rate ranges from 39% in New Mexico to 73% in Alaska. On the average, 46% of those reviewed are being terminated from the benefit rolls.

As shown in the attached tables, the rate of "cessation" or benefit termination--in the range of 45-50 %--is comparable to the rate over the period FY1978-80, prior to the implementation of the accelerated review. (A relatively high rate of cessation should be expected between 1982-84, as the first of the required 3-year reviews are undertaken. Not only will this be the first time that many DI beneficiaries have been reexamined, but also SSA is using procedures to select candidates for review that are targeted toward those with the greatest probability of ineligibility.)

A number of concerns have been raised by the terminations now taking place at the State agency level. Many people being denied benefits have been on the rolls for a number of years, and there has been a large number of appeals. On appeal, administrative law judges (ALJs) are reversing the State agency decisions and reinstating benefits in 60-65% of the cases. (The rate of reversal by ALJs has run about 60-65% since FY79.)

Certain of the essential issues raised by the CDI situation include the following:

- the ability of State agencies to handle the increased CDI workload;
- the uniformity, or lack thereof, in decisionmaking and the basic standard of disability from one stage of adjudication to the next;
- the proper treatment of beneficiaries already on the rolls prior to enactment of the 1980 amendments relative to those now coming onto the rolls;
- the meaning of "permanently impaired" in the assessment of whether an individual is subject to the 3-year review cycle;
- the appropriateness of current law and practice whereby benefits may be terminated when the agency is unable to show that the disabling condition has improved, but nevertheless finds the individual ineligible for disability benefits;
- the adequacy of evidence development procedures;
- the amount of advance notice received by beneficiaries both prior to review and prior to termination; and
- the length of time prior to appeal, during which benefits are not payable.

Attached are charts which illustrate the basic disability determination process and the stages of adjudication. Also attached is a set of tables showing historical data on CDI activity, State-by-State allowance/denial rates, ALJ reversal rates, and ALJ workload data.

Pending legislation is described on pages 113-122 of the disability insurance bluebook (August 1982). Cost estimates provided by the social security actuaries are attached.

—COMPARISON OF CONTINUING DISABILITY INVESTIGATIONS (CDI'S) PROCESSED TO TOTAL DISABLED-WORKER BENEFICIARIES OVER THE YEARS

Fiscal year	CDI's processed (DI and concurrent cases only)	DI-worker beneficiaries (in millions)	Number of CDI's per 1,000 DI-worker beneficiaries
1970	[1] 167,000	1.493	111.8
1973	[1] 142,000	2.017	70.4
1974	[1] 120,000	2.237	53.6
1975	[1] 116,000	2.489	46.6
1976	[1] 129,000	2.670	48.3
1977	107,220	2.834	37.8
1978	83,651	2.880	29.0
1979	94,084	2.870	32.8
1980	94,550	2.861	33.0
1981	168,922	[2] 2.835	59.6
Oct. 1, 1981 to June 28, 1982	243,785	[2] 2.723	89.5

[1] Figures provided by SSA in 1977, but not currently verifiable.
[2] Estimates based on intermediate II–B assumptions in the 1982 Trustees' Report.

Source: SSA and Social Security Bulletin, Annual Statistical Supplement, 1980.

—CONTINUING DISABILITY INVESTIGATION ACTIVITY AND STATE AGENCY WORKLOAD UNDER THE DI PROGRAM, FISCAL YEARS 1981–82 [1]

Fiscal year	Total DI cases	
	Sent to State agencies	Reviewed by State agencies [2]
1980	123,310	94,550
1st quarter 1981	34,911	29,763
2nd quarter 1981	33,887	28,029
3rd quarter 1981	99,330	41,813
4th quarter 1981	141,992	69,317
Total 1981	310,120	168,922
1st quarter 1982	82,133	86,026
2nd quarter 1982	149,824	87,669
Total, first-half 1982	231,957	173,695

[1] Includes DI and concurrent DI/SSI cases. Excludes purely SSI disability cases.
[2] These figures do not include CDI's where the State agency has not had to make a new medical determination of disability.

Source: SSA, July 1982.

—PLANNED CONTINUING DISABILITY INVESTIGATIONS (CDI) ACTIVITY REFLECTED IN PRESIDENT'S FISCAL YEAR 1983 BUDGET, DI AND SSI PROGRAMS COMBINED

Processed CDI's	Fiscal year—			
	1980	1981	1982	1983
Regularly scheduled CDI's			152,000	152,000
Additional CDI's			415,000	654,000
Total	159,600	257,100	567,000	806,000

Source: Fiscal year 1983 SSA justifications to appropriations committees, supplemented by data supplied by SSA.

Note: These figures include CDI's where the State agency does not have to make a new medical determination of disability. These include cases where, for instance, the individual returned to work, as determined by SSA's district office staff.

—CONTINUING DISABILITY INVESTIGATION (CDI) CONTINUANCES AND CESSATIONS BY STATE AGENCIES, DI AND SSI COMBINED, FISCAL YEARS 1977–82[1]

Fiscal year	Total number of CDI reviews	Continuances	Cessations	Continuance rate (in percent)	Cessation rate (in percent)
1977	150,305	92,529	57,776	62	38
1978	118,819	64,097	54,722	54	46
1979	134,462	72,353	62,109	54	46
1980	129,084	69,505	59,579	54	46
1981	208,934	110,134	98,800	53	47
10/1/81–5/28/82	266,725	145,321	121,404	54	47

[1] Reflect continuance and cessation rates only at the State agency level—not at the district office or at the hearing or appeal levels of adjudication. These figures differ from the previous table in that they exclude CDI's where no new medical determination of disability by the State agency was required. Other factors have affected the individual's entitlement, such as his return to work.

Source: SSA, July 1982.

—ADMINISTRATIVE LAW JUDGE REVERSAL RATES—DISABILITY INSURANCE INITIAL DENIALS AND TERMINATIONS, FISCAL YEARS 1979–82

Fiscal year	Percent of cases reversed	
	Initial denials	Terminations
1979	56.4	59.5
1980	59.4	63.8
1981	59.0	61.5
1st quarter 1982	57.3	65.4

Source: SSA, July 1982.

—RECENT ALLOWANCE RATES FOR INITIAL CLAIMS AND CDI DECISIONS, STATE BY STATE, DI AND SSI COMBINED

[In percent]

Initial claims [1]		Initial CDI decisions [2]	
State	Allowance rate	State	Allowance rate
Rhode Island	41.5	South Dakota	79.6
South Dakota	41.3	Alaska	72.8
Vermont	41.2	New Hampshire	69.8
Nebraska	40.2	Hawaii	69.6
		Nebraska	69.3
Alaska	39.5	Minnesota	68.3
Delaware	38.9	Vermont	67.6
Wisconsin	38.6	Wyoming	67.6
District of Columbia	38.5	Washington	67.0
Minnesota	37.2	Delaware	66.1
Utah	36.6	Maryland	64.5
Arizona	36.5	North Dakota	63.5
Iowa	36.1	Utah	62.6
Hawaii	35.6	Iowa	62.6
Indiana	34.7	Colorado	62.2
Kansas	34.6	Montana	61.3
Maine	34.3	Arizona	60.8
Connecticut	33.9	Missouri	60.4
North Carolina	33.9	North Carolina	60.2
New Jersey	33.7	Mississippi	60.1
Missouri	33.0	Massachusetts	59.9
Ohio	32.8	Oregon	59.7
North Dakota	32.8	Virginia	59.4
Illinois	32.6	Connecticut	59.3
Montana	32.5	Kentucky	58.3
Pennsylvania	31.9	South Carolina	58.0
New Hampshire	31.6	Ohio	57.9
Colorado	31.6	Maine	57.8
Nevada	31.5	Nevada	57.7
Wyoming	31.1	District of Columbia	57.4
Virginia	31.0	Kansas	56.6
South Carolina	30.9	Alabama	56.2
Oregon	30.9	West Virginia	55.9
Washington	30.8	Rhode Island	55.7
Florida	30.7	Indiana	55.4
Texas	30.3	Pennsylvania	55.3
Tennessee	30.2	Tennessee	54.8
Idaho	29.6	Michigan	54.5
California	28.9	Florida	54.1
Oklahoma	28.7	Georgia	53.5
Kentucky	28.5	Illinois	52.4
Maryland	28.2	California	52.1
Massachusetts	28.0	Idaho	51.5
Michigan	27.8	Oklahoma	51.5
Alabama	27.6	Wisconsin	49.8
Mississippi	27.5	Texas	49.0
Georgia	25.7	New Jersey	48.7
New York	25.4	Arkansas	48.2
West Virginia	25.3	New York	47.5
Louisiana	25.2	Louisiana	46.8
New Mexico	25.1	New Mexico	38.8
Arkansas	24.3	Puerto Rico	29.0
Puerto Rico	19.3		

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[1] For fiscal year 1981.

[2] For period 10/81 to 5/82. Does not take appellate actions into account and excludes non-medical determinations.

Source: SSA, July 1982.

—REQUESTS FOR ALJ HEARINGS—RECEIVED, PROCESSED, AND PENDING TOTAL CASES[1]

Fiscal years	Requests received	Processed	Pending (end of year)
1960	13,778	20,262	5,959
1965	23,323	23,393	6,454
1966	22,634	23,434	5,654
1967	20,742	20,081	6,315
1968	26,946	25,939	7,322
1969	34,244	31,912	9,654
1970	42,573	38,480	13,747
1972	103,691	61,030	63,534
1974	121,504	80,783	77,233
1975	154,962	121,026	111,169
1976 (15 mo)	203,106	229,359	84,916
1977	193,657	186,822	91,751
1978	196,428	215,445	74,747
1979	226,200	210,775	90,212
1980	252,000	232,590	109,636
1981	281,700	262,609	128,164
1982	[2] 326,300	300,000	[2] 155,064

[1] Includes DI, OASI, SSI, and Black Lung cases.

Source: Estimate provided by SSA, OHA, July 1982.

—HEARINGS AND APPEALS STATISTICS, FISCAL YEARS 1973–81

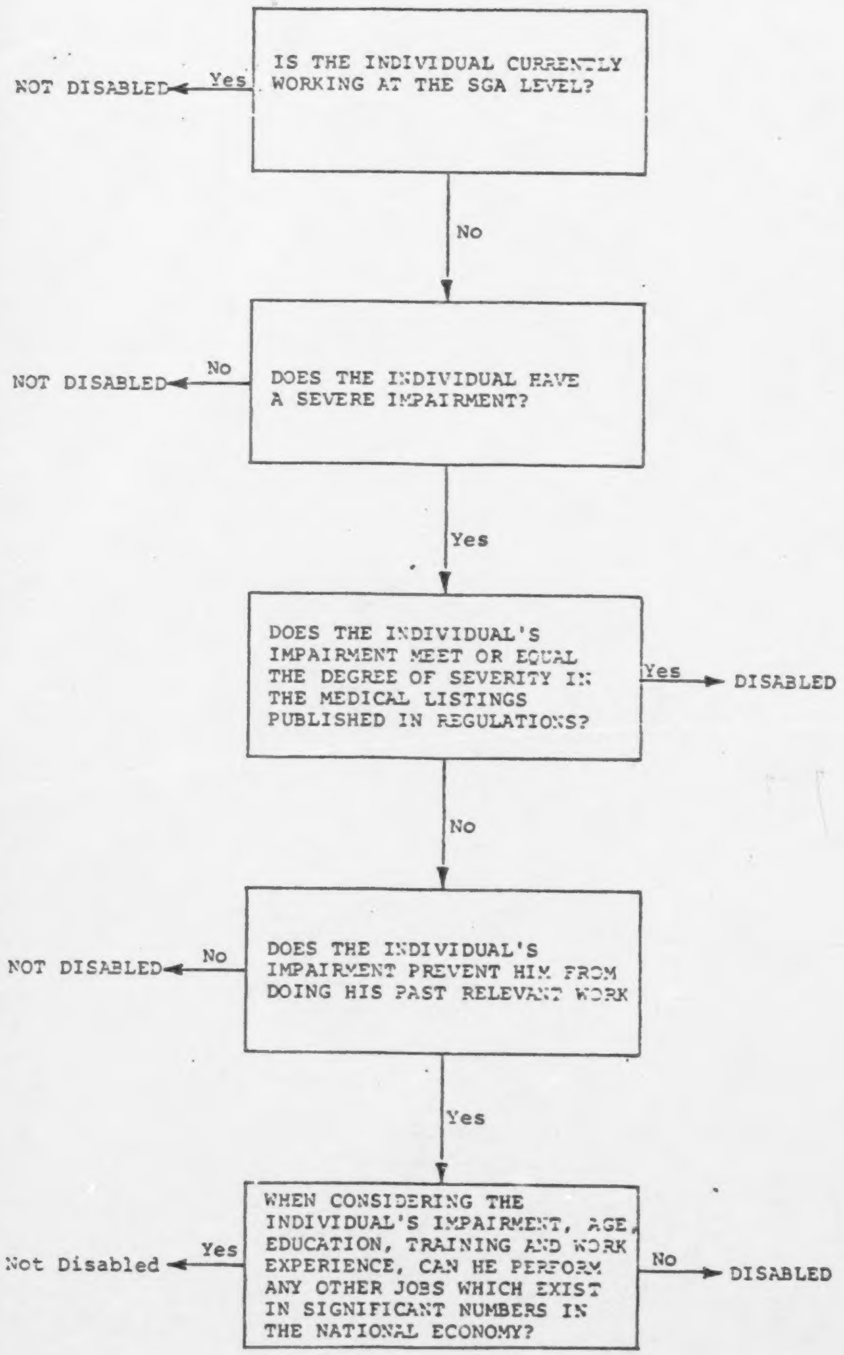
Fiscal year	Average number of ALJ's on duty [1]	Average support staff ratio [2]	Average hearings received per ALJ	Average dispositions per ALJ [1]	Average number of cases pending per ALJ [1]
1973	420	2.2	172	163	117
1974	478	2.7	254	169	122
1975	591	2.9	262	205	173
1976	647	3.6	244	277	153
1977	629	3.8	308	297	136
1978	657	3.9	299	328	128
1979	655	4.3	345	322	141
1980	669	4.4	377	333	169
1981	699	4.4	403	376	188

[1] Beginning in fiscal year 1978 includes regional chief ALJ's. Beginning March 1981 includes ALJs on detail from ICC. ALJ average dispositions are calculated to include the 9-month learning curve for new ALJs.

[2] Permanent staff fiscal year 1973–78; beginning fiscal year 1979 includes ALJ temporary positions.

Source: SSA, Office of Hearings and Appeals. 1982.

THE DISABILITY DECISION: A SEQUENTIAL EVALUATION PROCESS


IS THE INDIVIDUAL CURRENTLY WORKING AT THE SGA LEVEL?
Yes
NOT DISABLED
No
DOES THE INDIVIDUAL HAVE A SEVERE IMPAIRMENT?
No
NOT DISABLED
Yes
DOES THE INDIVIDUAL'S IMPAIRMENT MEET OR EQUAL THE DEGREE OF SEVERITY IN THE MEDICAL LISTINGS PUBLISHED IN REGULATIONS?
Yes
DISABLED
No
DOES THE INDIVIDUAL'S IMPAIRMENT PREVENT HIM FROM DOING HIS PAST RELEVANT WORK
No
NOT DISABLED
Yes
WHEN CONSIDERING THE INDIVIDUAL'S IMPAIRMENT, AGE, EDUCATION, TRAINING AND WORK EXPERIENCE, CAN HE PERFORM ANY OTHER JOBS WHICH EXIST IN SIGNIFICANT NUMBERS IN THE NATIONAL ECONOMY?
Yes
Not Disabled
No
DISABLED

STAGES OF DISABILITY DECISION-MAKING

	Administered by:	Time allowed to request next stage	Average time from request to decision[1]
INITIAL CLAIM OR CONTINUING DISABILITY INVESTIGATION	SSA District Office or State Agency (DDS)*	60 days	46 days
RECONSIDERATION	State Agency (DDS)*	60 days	39 days
HEARING	SSA's Administrative Law Judges	60 days	165 days
APPEAL	SSA's Appeals Council	60 days	66 days[2]
FEDERAL COURT REVIEW	Federal Court System	--	Not Available

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*Disability Determination Service.

[1] For DI cases including the DI portion of a concurrent case.

[2] Includes DI, OASI, SSI and Black Lung cases.

Senator **Armstrong**. The committee will come to order.

Today the Senate Finance Committee's holds hearings on social security's disability insurance program generally, and specifically on issues related to why 50 percent and more of those now receiving disability benefits and whose cases are being reviewed are having their assistance terminated.

If it is agreeable to members of the committee, I have a statement which I will insert in the record at this point but will not take the time to read or discuss in full.

Senator Heinz?

Senator **Heinz**. Mr. Chairman, thank you very much.

First, I would like to express my appreciation to both you and Senator Dole for holding this hearing. I remember the discussions we had, and I'm most appreciative.

I am going to abbreviate my opening statement. A full copy of my opening statement has been made available.

I would only note, Mr. Chairman, that this issue is extremely crucial. There is going to be at least one amendment, maybe more, offered on the debt ceiling bill to do something about this problem of continuing disability investigations.

The problem, very briefly, is that there is a tremendous volume of these redeterminations. The volume is growing at a fast rate, and I frankly think that every bit of evidence suggests that it is a volume that can't be intelligently managed or handled.

There is absolutely no question in my mind that individuals are being removed from the rolls at a rate far faster than Congress ever envisaged, let alone intended.

Originally Congress saw very little in the way of savings here—maybe $10 million. Right now OMB, or the President's budget, is looking at more than $3 billion in savings from these continuing disability investigations, and that was never even considered a possibility when the law was enacted in 1980.

Finally, there are large numbers of individuals who go through this redetermination, have their benefits cut off and undergo considerable pain and suffering, and then at some later time, have their benefits reinstated by the administrative law judge who rules that the termination was incorrect.

These are all symptoms of a process that is not working the way we intended it to work.

One of the best examples I have come across, and one that documents in some detail all of these claims that we are making against the current system, is the case of one woman from my own State of Pennsylvania, Kathleen McGovern of Philadelphia. She was found dead after having been notified previously of the fact that her social security disability determination had gone against her.

The staff of the Aging Committee and I investigated this case. We are releasing a letter today to the GAO asking for their review of this whole CDI process. That letter is accompanied by a letter which I sent to Secretary Schweiker detailing—in four pages worth of details—the specific shortcomings, mismanagement, shoddiness, and general insensitivity that we found in the administration of the specific case of Kathleen McGovern of Philadelphia. It is a most unhappy record. It is one that I believe we in the Congress have a responsibility to correct, not just for the Kathleen McGoverns but for all the thousands of our constituents who are being wrongly denied their disability benefits.

Mr. Chairman, in conclusion, I want to thank you for holding this hearing. I would like at this time just to mention that we are privileged to have with us today our secretary of labor and industry from the State of Pennsylvania, Mr. Barry Stern, who will be appearing on a panel later. As I understand it, Mr. Chairman, Mr. Stern will be called up as part of the first panel of witnesses, along with Dr. Cohen, who I see in the audience, and Dr. John Talbott. Another witness from Pennsylvania, Mrs. Shapiro, the executive director of the Pennsylvania Coalition of Citizens with Disabilities, was most unfortunately taken quite ill this morning and was unable to make the trip. Her testimony, however, will be made part of the hearing record.

Mr. Chairman, thank you very much.

Senator **ARMSTRONG**. Thank you, Senator Heinz.

[The prepared statement of Senator Heinz and attachments follow:]

OPENING STATEMENT BY SENATOR JOHN HEINZ

I want to commend the distinguished Chairman of the Finance Committee for holding this hearing. The problems surrounding the program of continuing disability investigations are so serious that they demand the urgent attention of this Committee and of the full Senate.

The goal of reviewing the disability status of individuals on the social security rolls is a sound and necessary principle. But the current program goes way beyond what Congress envisaged when it mandated the periodic reviews in 1980. And it is also clear to me that the program is not working well from the standpoint of equity to the individuals involved.

There are three major problems, as I see them:

First, the sheer volume of CDIs is growing at too fast a pace to ensure that disability beneficiaries receive the careful, complete medical reviews they deserve. When the Government of the United States suddenly begins running 600,000 to 800,000 people a year through a mass reexamination mill, there is a serious risk of trampling upon the rights of large numbers of individuals. We almost certainly add to the pressure on local officials to take shortcuts . . . and where we encourage individuals to take shortcuts, we create a climate conducive to error.

The second problem is that individuals are being removed from the rolls at a rate that far exceeds what Congress envisaged. Between October 1, 1980 and the end of May 1982—more than 220,000 people were terminated. Currently, the Social Security Administration is terminating 45 percent of the beneficiaries it reviews. When Congress passed the Disability Amendments of 1980, the periodic disability review was expected to produce no net savings during the first 3 years fiscal year (1982-84). And, during the 4 year period fiscal year 1982 through 85, the periodic reviews were projected to save $10 million. Yet, the President's fiscal year 1983 budget indicates that the CDI's will now save $3.25 billion in fiscal year 1982-84—or 325 times the original estimate. And SSA's internal projections of the CDI savings are even higher.

The third major problem with the CDI's is that large numbers of individuals, who are ultimately found to be legitimately entitled to benefits, are put through a harrowing and unnecessary ordeal. Mr. Chairman, 65 percent of the individuals who appeal their terminations to the administrative law judges have their benefits reinstated. But in the interim, they undergo long months without any benefits—in fact, a year or more is not uncommon; they suffer painful anxiety about how they will meet their family's obligations; and they frequently incur the additional expense of paying for the services of an attorney.

These three systemic problems with the CDI process demand an immediate resolution.

We must slow down the volume of CDI's to a level that is both manageable by State agencies and conducive to high quality reviews.

We must give beneficiaries some additional protection against unfair terminations by requiring the Federal Government to bear the burden of proof that an individual is no longer disabled.

We must extend the availability of benefits through the appeals process to reduce the hardship upon those who are terminated at one level of the Social Security Administration only to be reinstated at a higher level of judicial authority.

Mr. Chairman, the disability insurance trust fund is financially sound. The rate of new awards is at the lowest point in the history of the program, and roughly half the 1975 level. There is simply no need to take a meat axe to this program at the expense of men and women who contributed to this program throughout their working years.

We can—and must—make adjustments in the CDI program to restore balance to the system on behalf of beneficiaries and still preserve the sound principle of periodic disability reviews.

This hearing is a major step in that direction. In addition, I am today asking the General Accounting Office to undertake a major investigation of the process followed by the Social Security Administration in evaluating the disabilities of individuals suffering from mental illness.

The general problems with the CDI's—which I have already outlined in my statement—in combination with the special problems of evaluating mental disabilities, have together conspired to impose a special hardship on the mentally ill. The case of one Pennsylvania woman, Kathleen McGovern, is illustrative of this situation. I have already alerted Secretary Schweiker to my concerns about this individual case, in light of allegations that her death may have been a suicide. Her case is shocking—not only because of the way it was processed—but primarily because it is typical of what is happening to thousands and thousands of the mentally ill who are undergoing scrutiny by the Social Security Administration.

But it is my hope that the agony she experienced in her CDI investigation can be spared the tens of thousands more who will be reviewed in this process in the coming months.

Thank you, Mr. Chairman.

JOHN HEINZ, PA., CHAIRMAN

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United States Senate
SPECIAL COMMITTEE ON AGING
WASHINGTON, D.C. 20510

August 18, 1982

The Honorable Charles A. Bowsher
Comptroller General
U.S. General Accounting Office
441 G Street N.W.
Washington, D.C. 20548

Dear Mr. Bowsher:

As Chairman of the Special Committee on Aging, I am deeply concerned about the process followed by the Social Security Administration and the State agencies in determining whether individuals suffering from mental impairments are eligible for Social Security and Supplemental Security Income benefits.

I am therefore requesting the GAO to thoroughly evaluate SSA's regulations, policies and procedures for determining disability of those who are suffering from mental illness or mental retardation. In particular, I would like the GAO to evaluate any potential conflicts between these procedures and the substance of the law, and I would like the GAO to make specific recommendations that will ensure that the spirit of the law is accurately reflected in the procedures observed by SSA.

You are probably aware that several suicides have occurred in connection with the termination of disability benefits. In reviewing the circumstances surrounding one alleged suicide — the case of Kathleen McGovern — I noted serious deficiencies in the procedures for dealing with claimants with diagnoses of mental illnesses, and, in particular, the possible failure on the part of agency officials to evaluate the seriousness of suicidal tendencies. I pointed out these deficiencies in a letter to Secretary Schweiker, which is attached for your information. In particular, you should note the apparent discrepancies between the findings of the psychiatric consultative examiner and the physician employed by the State agency. According to the also-enclosed letter from Dr. Lebovitz, State agency physicians consistently disregard the reports of treating and consulting psychiatrists.

Various mental health organizations have also stated that many individuals with severe mental impairments are being denied disability because of the following reasons: 1) SSA's medical criteria do not reflect current professional standards and nomenclature; 2) the methods for evaluating the individual's capacity to work fail to reflect good professional practices; and 3) decisions are often based on insufficient medical documentation, often, on one brief consultative examination.

Mental health organizations also state that because the Social Security medical listings are not current, persons who are mentally disabled within the meaning of the law do not meet SSA's medical criteria. Further, those individuals who do not meet the medical listings are not afforded a realistic evaluation of their so-called "residual functional capacity". Therefore, the medical listings become the final arbiter of whether or not one is disabled.

Psychiatric consultants have publicly complained that the brief time allotted to them to evaluate the patient's condition is altogether insufficient to reach a valid conclusion about the individual's mental health, and the American Psychiatric Association (APA) has pointed out that the consultations are too cursory and too brief to be of value. I enclose a copy of the letter Dr. James Folsom sent to Commissioner Svahn, which spells out some of the concerns of the APA.

Because of the large numbers of mentally disabled individuals who receive Social Security and SSI disability benefits, and because large numbers of those diagnosed as mentally ill are being denied benefits or losing previously granted benefits, it is important that the Special Committee on Aging, with your assistance, make a thorough examination of the decisionmaking process and the criteria used to decide disability cases.

Because of the urgency surrounding the high rates of termination of disabled individuals, I am also asking the GAO to expedite this investigation and make a preliminary report to me as soon as possible. The GAO has been of considerable assistance to this Committee in the past, and I thank you, in advance, for your prompt attention to this request.

Sincerely,

JOHN HEINZ
Chairman

JH/fmh

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United States Senate
SPECIAL COMMITTEE ON AGING
WASHINGTON, D.C. 20510

August 3, 1982

The Honorable Richard S. Schweiker
Secretary of Health and Human Services
200 Independence Avenue, S.W.
Washington, D.C. 20201

Dear Mr. Secretary:

I am writing to you about Kathleen McGovern, a former social security and SSI beneficiary, who received notification that her disability benefits were to be terminated. Kathleen McGovern was found dead in her apartment and the allegation was initially made that she committed suicide as a result of depression caused by the threatened loss of her benefits. Whatever the final findings of the investigation of that issue, serious broader questions remain to be answered.

As Chairman of the Senate Special Committee on Aging, I immediately asked the General Accounting Office to undertake a review of the McGovern case. In addition, the Social Security Administration provided the Committee with the file on Kathleen McGovern. Our review of the case generated the following questions, which we would like answered at the earliest possible date.

Although the questions directly relate to Kathleen McGovern, the answers have a bearing upon the entire program of continuing disability investigations and, in particular, the processes employed in reevaluating the disability status of beneficiaries suffering from mental illness.

The first question is: Why does the file indicate contradictory statements by SSA and State agency personnel regarding the date of onset of Kathleen McGovern's disability? The Summary Fact Sheet states the onset date was established as June 30, 1975, when the claimant "began regular treatment at Einstein Day Hospital". Yet the Office of Disability Operations Medical Consultant's case analysis dated 6/17/82 begins: "This 40-year old woman began receiving title II DIB with an onset date of 6-78." Form SSA 2417 indicates date of onset was June 30, 1975. SSA Form 833 dated 3/17/82 indicates date of onset of 6/78, while SSA Form 833 dated 7/27/81 indicates date of onset of 6/30/75. Both 833s, with contradictory dates of onset, were signed by the same reviewing physician, [redacted].

Question 2: Why was the Senate Special Committee on Aging not supplied all the files on Kathleen McGovern upon request? Although SSA did supply the Title II Social Security file, the SSI file was not received. On the contrary, it was shipped to the Federal Storage Facility in Wilkes Barre, where it arrived on June 25, 1982, one week after the Committee's request. I ask that you recall this SSI file and make it available to the Committee staff.

Question 3: Why was the SSI file not associated with the Title II file at the time this concurrent Title II/SSI disability investigation was undertaken? We have learned that Kathleen McGovern's receipt of SSI benefits was not continuous, and that she filed a new SSI disability application in June 1978. Without the SSI file, we cannot determine whether new medical evidence was supplied upon reapplication.

Question 4: Why were normal procedures not used in processing Kathleen McGovern's disability termination appeal? This was a concurrent Title II/Title XVI case. An informational report of contact in the file, dated 3/16/82 and signed [redacted], reads:

> "Please note: a CDI reconsideration may only be filed on a Title II claim — concurrent and Title XVI only claims must file for a hearing."

The reconsideration filed September 8, 1981, and filled out by SSA personnel, as well as the reconsideration decision dated February 5, 1982, should not have been rendered. The case should have been immediately elevated to the Administrative Law Judge level.

Compounding this original error, a [redacted] from Philadelphia Downtown Social Security Office sent a memo to the DDS which reads:

> "We need to have a CDI decision made for the SSI benefits she (Kathleen McGovern) also receives.
>
> Since she receives SSA/SSI you should have made 2 decisions. SSA benefits stopped in 9/81. Also notify claimant was due process (sic)."

On the basis of this erroneous handling of the case, and the recommendations by SSA personnel, a second SSA-833 was completed and signed by two disability examiners and two reviewing physicians, and a notice of planned action (and reconsideration denial of benefits) was sent to Kathleen McGovern in March 1982.

It appears, therefore, that in the 7 months between the initial termination letter dated August 18, 1981, and the hearing application filed March 22, 1982, Kathleen McGovern went through a lengthy, stressful, and unnecessary reconsideration decision process.

SSA should have been aware that the CDI process itself generated considerable stress for Kathleen McGovern. Her signed statement dated July 14, 1981, indicated: "I suffered a nervous breakdown several years ago and after receiving this letter (notice of CDI investigation) my nerves are really bad, I don't want to go back to Bayberry State Hospital."

The summary medical report from Albert Einstein Medical Center, Daroff Division, for the hospitalization during 8/24/81 through 9/11/81, further documents the stress related to the CDI:

> "Mrs. McGovern was admitted 9/24/81 complaining of depression and suicidal thoughts. The depression was precipitated by the fact that on August 21 the patient found out that her social security check was being stopped. It made her extremely depressed and disoriented. She suddenly felt that she had nothing to live for and all her plans had collapsed. Consequently she was thinking of taking an overdose, however, she was able to realize that she needed help and went to the emergency room and subsequently was admitted to the unit."

Question 5: Why was there no documented effort by SSA or State agency personnel to evaluate Kathleen McGovern's suicidal tendencies? In addition to the suicidal expressions noted above, the report by the consultative physician, [redacted] dated 12/17/81, states at the very outset: "Patient to be admitted for suicidal ideation." This failure by SSA and State agency personnel to respond to serious suicide threats leads me to believe that either no — or very inadequate — procedural guidelines exist for such cases.

Question 6: Why were Kathleen McGovern's contradictory statements not evaluated and resolved? In an untitled questionnaire with the claims representative Holland's name at the top, dated 4/15/81, Kathleen McGovern responded that she attends "ball games, movies, and plays cards". An earlier response on the same form says she spends her days "cleaning, cooking, visiting friends and relatives, watching TV". All of these social activities conflict with her statement of 9/8/81 on the Report of Continuing Disability Interview. Under "Daily Activities", the box "engaging in social activities" was indicated as an area in which she had difficulty or needed assistance. Her explanation: "I do not socialize because I get very nervous in a crowd and I cannot function well." It appears that the response on 4/15/81 copied the precise words used in the question. Further, the consultative report of 12/17/81 clearly indicated that she was not doing the things indicated on 4/15/81. Yet there is no documented effort to resolve these contradictions.

Question 7: Why are there contradictions between the findings of the State agency and the consultative report by [redacted] date 12/17/81? For example, Dr. [redacted] describes Kathleen McGovern as "inadequate — Totally dependent on institutions, agencies and boyfriend to make all decisions. No interests. Unmotivated. Cannot shop for self. Cannot prepare meals except very rudimentary items." Yet the reconsideration decision dated 1/7/82, which was allegedly based in part on Dr. [redacted]'s report, states: "Although she depends on others and has structured her living to such, there is no marked restrictive qualities to her day to day living or her ability to interact with others". These two findings are in obvious conflict.

The reconsideration decision found her memory was "good". Yet Dr. [redacted] reported that her memory was "subjectively poor" and had deteriorated. Further, the reconsideration decision states: "She can adequately relate to people in a work setting." How did the examiner and the reviewing physician reach that conclusion, when the CE report describes her as "withdrawn, seclusive, stoic, isolated. Has no friends outside of a single boyfriend who is inadequate himself"? Yet the examiners, who never saw this woman, found she would have no problem relating to people in a work setting.

Question 8: What vocational evidence was used to reach the conclusion in the reconsideration that "Her relevant work history is that of a waitress, a semi-skilled light occupation which would require superfisual (sic) contacts and routine repetitive movements"? The vocational report which disability adjudicator [redacted] sent to Kathleen McGovern on April 13, 1981, and which was returned to SSA (date stamped April 27, 1981) is completely blank.

Yet the reconsideration decision was that she could perform her past relevant work as a waitress. She had not worked since 1972. On her hearing application she indicated that she tried volunteer work "and I was a nervous wreck after 4 days. I couldn't keep working." There was no development by SSA or the State agency of this volunteer work experience.

On her original application for disability benefits, she stated she had only worked 4 to 5 months as a waitress and that, moreover, she did not believe she had social security insured status. She later was the subject of an SSA investigation because of scrambled earnings. Kathleen McGovern indicated she had not worked for the employers listed on the earnings record background. In fact, a claims representative has a memo in file indicating that if her denial of employment is correct, she does not have insured status for disability. In short, there is a major question about the inadequate vocational development of this case.

Question 9: Why was [redacted] the reviewing physician who signed both the initial termination of benefits and the reconsideration decision of 1/13/82? Is it customary for the same physician to review the original decision and the appeal?

In closing, my review of this individual case raises two major concerns about the entire program of accelerated continuing disability investigations.

First, there is a real question as to how adequate SSA's procedures are for dealing with beneficiaries who are mentally ill. I am concerned that such beneficiaries have serious problems responding to the bureaucratic questionnaires sent out by the agency, and I question how well they can present their case while they are simultaneously suffering from symptoms like thought disorder, chronic depression, or social withdrawal. I think it is imperative that SSA take steps to advise SSA and State agency personnel of the need for a special effort on their part to make sure that beneficiaries and applicants who are mentally ill are capable of understanding the CDI process and are capable of complying with all aspects of it. If they require assistance, SSA should provide it.

Second, my review of this case indicates that this continuing disability investigation was characterized by incorrect procedures and an apparent failure to resolve contradictory evidence in the file. I am concerned that the sheer volume of CDIs, and the workload deadlines associated with them, contribute to hasty processing of cases. I would like to see SSA issue guidelines that will result in a more complete development of decisions. In particular, the rationale used by State agency personnel in support of their decision should be more elaborate and more specific in stating how the decision was reached on these matters where conflicting medical and vocational evidence is involved.

I would greatly appreciate that you make the SSI file on Kathleen McGovern available to the Senate Special Committee on Aging at the earliest opportunity. Your prompt response to the specific questions raised in this letter would also be appreciated.

Sincerely,

JOHN HEINZ
Chairman

JH/fmt

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TELEPHONE 681-9177

June 22, 1982

Senator John Heinz
2031 Federal Building
Pittsburgh, PA 15222

Dear Senator Heinz:

I am in the private practice of psychiatry. In my work I am seeing injustice brought on by the Social Security Disability program that should not be permitted. Many of my patients, who are barely surviving because of their mental health conditions, are being systematically harassed with terminations and appeals, which are aggravating their illnesses, and causing great suffering.

I have had personal experience where my reports, and those of the psychiatrists consulting for Social Security, have been totally ignored, and disability payments were unjustifiably terminated by bureaucrats whose only interest seems to be to save money. In the majority of the appeal cases that I have been involved in, these decisions to terminate disability were reversed once I presented the evidence to the administrative law judges.

Before me, as I write this letter, I have a review form for the case of a patient for whom I had to give testimony last August to help her receive disability. At the time of the appeal I testified that she was totally and permanently disabled by her mental illness. The review being requested now, after such a short time, is nothing more than harassment, which will end up causing this patient mental anguish, and, for the second time in a year, loss of money for lawyers fees, etc..

I do not take issue with the government's right to dispense or not dispense disability payments under social security. I do take issue with the unfairness of the bureaucratic harassment of a segment of the population that is most vulnerable and impotent, the mentally ill.

If you have concern for your constituents, and wish to pursue this further, I can supply many names, dates, cases, etc..

Sincerely yours,

Allen E. Lebovitz

Allen E. Lebovitz, M.D.

AEL/sbs

American Psychiatric Association
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June 29, 1982

John Svahn
Commissioner
Social Security Administration
Department of Health & Human Services
P.O. Box 1585
Baltimore, MD 21203

Dear Commissioner Svahn:

On behalf of the American Psychiatric Association, a medical specialty society representing over 27,000 psychiatrists nationwide, I am pleased to respond to your call for comments on proposed regulations amending and revising the medical evaluation criteria for both the Social Security Disability Insurance and Supplemental Security Income disability programs, (Federal Old-Age, Survivors, and Disability Insurance; Revised Medical Criteria for the Determination of Disability, 20 CFR Part 404) published in the Thursday May 6, 1982 Federal Register (Vol 47, No 88).

As you are aware, the APA has been deeply concerned about the current conduct of the SSDI program, based in large part on the growing body of evidence attesting to an adverse impact upon mentally ill persons either now under investigation for continuing disability and retention of the SSDI rolls, or first applying for disability benefits. We well recognize that many of the apparent difficulties facing such individuals are based in statute, not regulation. For example, the statutory requirement that a person be deemed ineligible for SSDI if he or she has the residual functioning capacity to perform any work available in the national economy has certain unique perverse repercussions for the mentally ill. The availability of employment which, it would appear, but without regard to such person's disabling psychiatric illness, a mentally ill person may be able to perform, does not, mean for such individuals, that such employment is possible. I am sure that you understand, for example, that often it is impossible for a mentally ill person to negotiate a ten-block but ride to a place of employment by virtue of the illness itself.

Other difficulties are based in practice -- operating procedures which, due to the tremendous volume of casework now thrust upon the separate state claims examiners may not be consistent with SSA regulation. We know, for example, that SSA has urged special attention be taken in notification and evaluation of the mentally ill -- whether applying for SSDI for the first time, or undergoing a CDI. Such "going the extra mile," as SSA staff has described this effort, has simply not occurred, to the ultimate detriment of many of the mentally disabled. We further know that there are insufficient staff psychiatrists at the state level to provide the special technical expertise necessary to assure appropriate interpretation and review of disability case files. Sufficient numbers of properly and clinically trained claims examiners are simply not available to either keep pace with the increased workload of CDI reviews (approximately 31,000 per month this year) or to make the kinds of clinical judgments appropriate based upon a clear medical record. Further, we are concerned that insufficient attention is being paid at that initial review level to thorough evaluation of vocational as well as the medical factors in the disability determination process. The SSA's own five-step disability determination process is not followed completely, again, particularly adversely impacting upon the mentally ill.

In fact, however, some of the difficulties, particularly for the mentally ill, are based on the so-called "Medical Listings," the subject of the proposed rulemaking and upon which we are now pleased to provide our clinical expertise and comment. It should be noted at the outset, that APA rehabilitation experts have recently completed a chapter on "Mental and Behavioral Disorders" which will appear in the new AMA publication, Guides to the Evaluation of Permanent Impairment, and which provides invaluable advice and sets forth principles which may well be appropriate guides upon which claims examiners should rely when interpreting the listings.

Our substantive recommendations are specifically addressed to Sections 12.03 and 12.04 (Functional Psychotic Disorders and Functional Nonpsychotic Disorders). As well, we are concerned about the nomenclature utilized in these sections of the regulations. Each will be discussed in turn.

Section 12.03 - Functional Psychotic Disorders

Current regulations require that patients suffering from mood disorders, schizophrenias or paranoid states evidence both A and B:

A. Manifested persistence of one or more of the following clinical signs:

1. Depression (or elation); or
2. Agitation; or
3. Psychomotor disturbances; or
4. Hallucinations or delusions; or
5. Autistic or other regressive behavior; or
6. Inappropriateness of affect; or

7. Illogical association of ideas;

B. Resulting presistence of marked restriction of daily activities and constriction of interests and seriously impaired ability to relate to other people.

Our suggested change in "A" would eliminate the current requirement that patients manifest active psychotic symptoms upon examination. Instead, our language recognizes and adopts the accepted professional practice in psychiatry to take into account evaluating the nature and severity of a patient's illness, medically documented persistence of psychotic symptoms and signs, even if those signs are not continuously present, and thus may not be evident at the moment of the examination.

Requiring that acute clinical signs be manifest at the time of the examination fails to assess fairly and adequately mental illnesses characterized by an intermittent pattern of symptoms and signs or mental illnesses where overt symptoms and signs are controlled by medication. Experience has shown that where a patient demonstrates at least two of the "B" criteria (marked restriction of daily activities, constriction of interest or impaired ability to relate to other people) in the presence of documented intermittent clinical signs or signs and symptoms controlled by medication, the illness is disabling. Moreover, these disabling effects are not limited only to those periods where acute symptoms and signs are evident.

Our proposed change in "B" would modify the requirements that an individual demonstrate three major impairments in combination with the clinical signs to be designated per se disabled. Good clinical practice indicates that "marked restriction of daily activities" or "seriously impaired ability to relate to other people" alone might be sufficient to establish presumptive disability, and certainly, coupled with "constriction of interests", either should establish per se disability.

Further, we recommend that any evaluation of the impairments set forth in "B" should consider such issues as frequency, appropriateness, autonomy and comprehension. For example, if, to ascertain potential resriction of daily activities, it were asked whether the patient cooked, it would be important to further learn whether that was once a year, or three times a day, and whether the patient were cooking food or using the stove inappropriately. Only if such issues are considered can a verifiable determination for or against disability be made.

Consistent with these recommendations, we propose that Section 12.03 of these regulations be modified to read as follows:

A. Medically documented persistence, either continuous or intermittent (even if medication may have reduced in some measure the intensity) of any one of the following clinical signs:

1. Depression (or elation); or
2. Agitation; or
3. Psychomotor disturbances; or
4. Hallucinations or delusions; or
5. Autistic or other regressive behavior; or
6. Inappropriateness of affect; or
7. Illogical association of ideas;

B. Resulting persistence documented as to frequency, appropriateness, autonomy and comprehension of at least two of the following impairments:

1. marked restriction of daily activities
2. constriction of interests
3. seriously impaired ability to relate to other people.

Section 12.04 Functional Nonpsychotic Disorders

The current regulations parallel Section 12.03 requiring "manifested persistence of one or more" of a list of 7 clinical signs (Part A) and "resulting persistence of marked restriction of daily activities and constriction of interests and deterioration in personal habits and seriously impaired ability to relate to other people" (Part B).

The changes we propose in Section 12.04 relect similar concerns as articulated above in reference to Section 12.03. As above "A's" medically documented clinical signs, even though not evident at the moment of the examination should, if 3 of the 4 impairments ("B") are also met, constitute a suffcient predicate for a finding of per se disability. Further, the descriptors "demonstrable" "persistent" and "recurrent" are deleted from the list of clinical signs since they are redundant.

Thus, we propose that Section 12.04 of the regulations be modified as follows:

A. Medically documented persistence, either continuous or intermittent, (even if medication may have reduced in some measure the intensity) of any one of the following clinical signs:

1. Structural changes mediated through psychophysiological channels (e.g., duodenal ulcer); or

2. Periods of anxiety, with tension, apprehension, and interference with concentration and memory; or

3. Depressive affect with insomnia, loss of weight, and suicidal preoccupation; or

4. Phobic or obsessive ruminations with inappropriate, bizarre or disruptive behavior; or

5. Compulsive, ritualistic behavior; or

6. Functional disturbance of vision, speech, hearing, or use of a limb with demonstrable structural or trophic changes; or

7. Deeply ingrained, maladaptive patterns of behavior manifested by either:

   a. Seclusiveness or autistic thinking; or

   b. Pathologically inappropriate suspiciousness or hostility;

B. Resultant persistence, documented as to frequency, appropriateness, autonomy and comprehension of at least three of the following impairments:

   a. marked restriction of daily activities;

   b. constriction of interests

   c. deterioration in personal habits

   d. seriously impaired ability to related to other people

Nomenclature

The current regulations use outdated nominclature inconsistent with that employed by practicing professionals. This lack of consistency creates confusion not only for the treating psychiatrist submitting information to the Social Security Administration about his or her patient, but also makes SSA evaluation of such disability unnecessarily difficult. Reports prepared by psychiatrists using current diagnostic categories and descriptive terms will, in effect, have to be first "translated" by SSA claims examiners. Not only is this costly and time-consuming, but it introduces the potential for errors in decision-making due to simple misunderstandings based on differing terminology.

We note, for example, that in Section 12.04, one of the disorders referred to is "neurotic disorders." Such terminology no longer is utilized in psychiatric clinical diagnosis and practice. Hence, its utility is severely limited.

For these reasons, then, we suggest that the descriptions of symptoms, clinical signs and diagnostic categories be made consistent with the Diagnostic and Statistical Manual of Mental Disorders III — the current manual.

We are cognizant that much of the disability determination process is based on judgment of the levels of the intensity of signs, symptoms and impairments. However, we strongly believe that such judgements should be based on the skillfully developed, medically appropriate clinical evaluations conducted by psychiatrists (and psychological testing where appropriate). We would hope, therefore, that as claims examiners utilize these listings, that the latter reflect accurately the state of the art and that the former are appropriately trained to utilize the care materials provided by attending psychiatrists and other physicians.

The APA hopes that you will act favorably upon our recommended changes in the Medical Listings, but also hopes to work directly with you and your Disability Office in our mutual efforts to assure that statutory, procedural as well as regulatory roadblocks are lifted to assure that those individuals deserving and in need of disability insurance are not frustrated in their legitimate claims.

Sincerely,

James Folsom MD

James Folsom, M.D.
APA Committee on Rehabilitation

JF/TF:aw

Senator **Armstrong**. Senator Dole? Senator Roth?

Senator **Roth**. Thank you, Mr. Chairman. I too have a statement. I will not read it in its entirety, but I would like to summarize at least part of what it says.

When Congress mandated in 1938 that social security disability cases should be reviewed every 3 years, I supported this effort. However, something has gone very, very wrong, as Senator Heinz has said. Disability recipients who are terminated have the right to appeal, and the Social Security Commissioner himself has stated that it can take 15 months to have a hearing. Fifteen months without any income is 15 months too long if you are disabled, unable to work and support yourself and your family. So I have many questions about this review process.

Why does it take 15 months? Why are the administrative law judges reversing termination decisions 67 percent of the time? Why does the Social Security Administration view a case one way and the administrative law judge another? Are different standards being used? Why are these disabled people made to pay the price for erroneous decisions? How do we expect these people to live in the meantime, while the bureaucrats are backlogged, disagreeing over standards?

So, Mr. Chairman, I want to congratulate you for holding these hearings and hope that they will come up with some answers to these questions.

Senator **Armstrong**. Thank you, Senator Roth.

[The prepared statement of Senator Roth follows:]

TESTIMONY OF SENATOR WILLIAM V. ROTH, JR.

In 1980, Congress mandated that social security disability cases should be reviewed every 3 years. I supported this effort because in the past, some cases were never reviewed and client files were not updated files were not updated to take into account medical advancements or improvements in the medical status of claimants.

However, something has gone very very wrong. Disability recipients who are terminated have the right to appeal, and the Social Security Commissioner himself has stated that it can take 15 months to have a hearing. 15 months without any income is 15 months too long if you are disabled, unable to work and support yourself and your familiy.

I have many questions about this review process. Why does it take 15 months? Why are the administrative law judges reversing termination decisions 67 percent of the time? Why does the Social Security Administration view a case one way and the administrative law judge another way—are different standards being used? Why are the people—these disabled people—made to pay the price for erroneous decisions? How do we expect these people to live in the meantime—while the bureaucrats are backlogged, disagreeing over standards?

I, for one am glad we are having this hearing. Maybe we can get some answers to my questions. I hope we can find a solution soon—we cannot continue to have disabled people suffering through no fault of their own.

Senator **Armstrong**. Senator Dole?

Senator **Dole**. I will just take a moment; I know my colleagues are waiting to testify. I'd like to say at the outset that I appreciate Senator Armstrong holding these hearings.

I want to assure those who are concerned about the disability insurance program that it hasn't been a lack of interest in the subject matter that has delayed the hearing. It is just that we have been busy with some other important matters that aren't quite yet complete, namely the tax bill. However, I understand the need to turn to and address this problem.

I'd like to remind my colleagues that we passed the 1980 disability amendments in the 96th Congress under the Carter administration. That bill passed the Senate by a vote of 87 to 1. There was a great deal of support for reviewing some of the problems in the DI program. Since then, we have learned that we might be losing as much as $2 billion annually from people who are on the DI roles but who are not disabled under the meaning of the law.

I don't for 1 minute think we should retreat from the position that if you are not disabled under the meaning of the law you shouldn't receive benefits. We have to insist on that. That doesn't mean that some problems may not have developed in the process of weeding ineligibles out of the system, as mandated by the 1980 amendments. That's what we are here today to try to look at in a reasonable way.

I must say the House Ways and Means Committee subcommittee had extensive hearings on the DI program and did report out a bill. That bill hasn't gone anywhere though, which indicates the difficulty of trying to reach consensus in this area. In any event, this is a matter that deserves our immediate attention. I know that different members have different ways to approach it. I would just urge my colleagues not to rush to judgment. Give us a little time; don't try to load up something on the debt ceiling, because we are going to have to resist it. Give us time to work with the different points of view and see if we can't be constructive in finding some way to stop some of the abuses that have occurred.

The case that Senator Heinz mentioned is certainly one that has been repeated many times; but there are also hundreds of cases that ought to be addressed. I hope you will believe that we are sincere in our efforts to try to reach a responsible consensus and will act very quickly. Hopefully, when we come back from recess we can report a bill out of this committee that will address the concerns of every member.

So, Mr. Chairman, I thank you.

Senator **Armstrong**. Thank you, Senator Dole.

Senator Chafee, do you have a statement at this time?

Senator **Chafee**. I have a statement, Mr. Chairman, but I will submit it for the record. Thank you very much.

Senator **Armstrong**. Thank you very much.

[The prepared statement of Senator Chafee follows:]

OPENING STATEMENT OF SENATOR JOHN H. CHAFEE

I am pleased to be a part of the Finance Committee's efforts to investigate the effects of the 1980 Social Security Disability Amendments.

These amendments require the Social Security Administration to review cases of Social Security Disability Insurance recipients at least once every three years—except where an individual's impairment is considered permanent.

The Bellmon Amendment, as this legislation is known, was in response to a concern that the SSDI program was growing out of control. The disability program pays $18 billion a year in benefits to 4.6 million people, whose medical or mental conditions prevent them from working. However, it appears that the efforts being made to ferret out the ineligible recipients has had the effect of swinging the pendulum too far in the other direction. And questions concerning the fairness of the investigation and review process are justifiably being asked.

It heartens me to note the numerous bills that have been introduced which seek to remedy the current situation. The efforts of my colleagues to end the injustices inflicted on thousands of disability recipients are commendable. I also believe that special thanks should be given to Chairman Dole for scheduling these hearings.

The Social Security Disability Insurance program is an important part of the Federal government's "safety net" to protect those persons who can no longer support themselves through work. SSDI is not a welfare program. There is no so-called means test to determine benefits. Rather, the recipient's benefits are based on his or her contribution to the program.

For almost 5 million workers and their dependents, this essential program has made the difference that allowed severely disabled people to continue to support themselves and their families. Older workers, in particular, has been able to collect benefits under this program when their physical and mental illnesses have prevented them from continuing in their former work. In fact, more than half of the disabled workers on the rolls are 55 or older.

In response to a rapid growth in the disability program Congress passed legislation in 1977, and again in 1980, which sought to improve the incentives for disabled beneficiaries to return to work. This legislation was accompanied by an effort on the part of the Social Security Administration to tighten the management of disability programs by working toward more uniform disability determinations and by re-examining beneficiaries more frequently to ascertain whether they remained disabled.

When a disabled worker is denied benefits or terminated from the SSDI roles, it is possible for the worker to appeal. The disability appeals process involves four distinct levels—the State agencies, the Administrative Law Judges (ALJs), the Appeals Council and the Courts.

The number of cases reversed on appeal has been increasing, with most of the increase occurring at the ALJ level. Since, 1964, the percentage of reversals has tripled. In my own State, the SSA has terminated the payment of monthly disability benefits to 474 Rhode Islanders in 1981. This represented a cessation rate of 33 percent as a total of 1428 cases were examined since the review began in April, 1981. Thomas Fenton, the District Manager in Providence has informed me that the reversal rate at the ALJ level is above 60 percent.

A lack of uniformity among the different levels of adjudication is partially responsible for a situation in which State agencies are denying about 70 percent of initial claims while the ALJs are awarding benefits by reversing the State agencies in about 60 percent of the cases.

I am alarmed at the problems surrounding SSDI since the stepped-up review process was mandated in 1980. Disability beneficiaries are being terminated from the rolls—many of whom never experienced any improvement in their condition. Beneficiaries granted benefits in the past are currently being evaluated under more stringent disability standards. For those recipients terminated and who persist through the appeals process to the ALJ level, more than half are reinstated. There is an increasing consensus that the problems with the disability review process need to be addressed immediately!

Given the present scale of the SSDI program—2.8 million recipients receiving $1.1 billion each month—the objective of carrying out the 1980 review is a laudable one. However, there must be a more exact and, therefore, more equitable way of doing so.

It is my sincere hope that the facts presented during this hearing will result in positive action on the part of this Congress. The situation, as it is today, is not tolerable and cannot with conscience be allowed to continue.

Senator ARMSTRONG. Members of the committee, we are honored to be joined this afternoon by four of our colleagues, each of whom I think has a statement on this subject.

Senator Cohen, did you want to speak on this? I understand that you have conducted some hearings on this subject yourself, so the committee is particularly interested in your observations about it.

STATEMENT OF HON. WILLIAM S. COHEN, U.S. SENATOR FROM THE STATE OF MAINE

Senator COHEN. Thank you, Mr. Chairman. I have a statement, and I would ask unanimous consent that it be included in the record in full. I will try to summarize from it.

I would like first of all to associate myself with the remarks of the distinguished chairman of this committee, Senator Dole. He says, in effect, that Congress went on record back in 1978 saying that this is an area that we think may be subject to abuse to the extent that people who are not qualified to receive these benefits are receiving them and that should be stopped.

By the same token, we want to see that those who are severely disabled continue to receive their benefits. So I have no question that the goal of what the 96th Congress did was correct, but I do have some problems with the procedures that have been developed to date.

Last May, Senator Levin and I conducted hearings in the Oversight Subcommittee on Government Affairs, and we found out a number of things: One, we found that the Social Security Administration's anticipated 20-percent estimate—20 percent of those people who were receiving benefits ought to be discontinued—was doubled. We found that they were terminating 40 percent of the cases reviewed. Out of those 40 percent, we found that of those who appealed those decisions more than two-thirds were actually being reversed on appeal. So we found that people who had had their benefits denied through the administrative process before their cases got to the administrative law judges, who determined that in fact they were entitled to continue to receive those benefits, had to wait as long as 9 months, 12 months, sometimes even 15 or 16 months, with very severe hardships being inflicted upon those people.

I know Senator Levin has one case to be discussed at length, and I won't preempt his discussion of it, but I think it is one of the more dramatic cases. I'm sure we could point to many others, as Senator Heinz has found in his own State.

Senator Dole's point is also correct that, for every egregious error we find, we can probably find a number of people who have been receiving benefits who are no longer entitled to them.

But we have a problem: When 40 percent of the people are being terminated, double the amount anticipated, and two-thirds of those decisions at the State level are being overturned, something is wrong with the procedure.

I would just summarize the major points that we discovered during the course of our hearing: First, the Social Security Administration does not provide the claimants with an adequate notice which would explain the gravity of the review and the beneficiaries' responsibilities. Instead they have been sending out what I believe is a highly misleading notice which simply informs the claimant that his case or her case is "under review" to determine if he "continues to meet the requirements."

Now, I don't suggest that the Social Security Administration is acting out of deception or complicity or out of malice. What they were concerned about was that they might shock the beneficiary if they said, "Your benefits may be terminated." They didn't want to do that, so they sent out a card saying "It is coming up for review to see whether you have complied with the requirements." I think that is misleading because it doesn't tell them enough. It didn't tell them, for example, that they would have the burden of coming forward and producing medical evidence, that their prior medical history was totally discounted, and there would be no consideration given to the past medical record. So, to the extent claimants did not realize that they had to supply that medical information, they were prejudiced very severely.

That was a major deficiency, in my judgment—the lack of adequate notice. You ought to tell somebody "We are going to require you to prove your disability, from scratch, starting over again. And you've got the burden of proof," if in fact that is the system we have. We are going to make recommendations about changing the process; a number of members have recommendations. But it seems to me that fair play requires that we tell the people what is going to happen in that particular procedure.

Second, no face-to-face interviews are held with the claimants until they actually appear before an administrative law judge. It seems to me this absence of personal contact gives the claims examiner an incomplete picture of the claimant's true condition. I think it also reinforces the beneficiary's feeling of bureaucratic indifference, to the extent that it is all conducted in some office with no personal contact whatsoever until the claimant appeals to an administrative law judge. I think that is a bad system in itself.

Third, there are different standards being applied, one by the State agencies and another by the administrative law judges. For example, notwithstanding the Federal court decisions, notwithstanding Federal regulations, notwithstanding congressional intent, there has been a decision made by the Social Security Administration to downplay, if not indeed eliminate, the consideration of personal pain. It has historically been the case that if you have objective signs of pain supported by medical evidence, would be a factor to be taken into account in determining whether a person suffers from a severe disability. We are talking about disabilities which totally disable him, not just for that job that he was occupying but for any job in the country, anywhere. So it is a very severe test to begin with. And yet we find different standards being applied. Under so-called POMS, the program operating manual system, the SSA they directed that consideration of pain in effect be eliminated, and that is contrary to what the administrative law judges were applying.

We have different standards being applied. Having a uniform procedure, I believe is imperative.

Fourth, we found in a number of cases that the medical files which the claims examiners rely upon are incomplete. They lack current medical evidence from the treating physician.

Fifth, there is no presumption of validity accorded to the initial decision which originally entitled the claimant to receive those benefits. Instead, the SSA has a system of "zero-based eligibility," in which a claimant has to prove all over again that he or she is entitled to benefits.

Sixth, in a number of cases individuals whose medical conditions have actually deteriorated since they started to receive benefits many years ago are having their benefits terminated.

Those were the major findings from our subcommittee hearing. In short, the hearing revealed a disturbing pattern of misinformation, incomplete medical examinations, inadequately documented reviews, bureaucratic indifference, erroneous decisions, financial and emotional hardships—I believe we had evidence of eight suicides that occurred following the termination of the disability payments—and a very overburdened system.

Senator Levin and I have a bill which we have introduced which would do the following: It would shift the burden of proof from the disability recipient to the Government to show why the benefits ought to be discontinued; it would require a showing of medical improvement or evidence of working, fraud, or error before the termination; it would impose uniform standards, subject to public notice and comment, on all the decisionmakers; it would require State agencies to conduct face-to-face interviews with those whose benefits are likely to be terminated; it would eliminate reconsideration by the State agency to shorten the appeals process—as it is now, the State agency makes an initial determination, and if you are turned down, you can apply for reconsideration, and then you can appeal to an administrative law judge, so we would exclude that second step. Finally we would include a definition of pain in the statute and continue the benefits up until the administrative law judge stage, so that the benefits would continue pending appeal. If the administrative law judge then sustains the termination decision, that person would have an obligation to make restitution for benefits that were improperly received up to that time.

Now that brings me to the point that Senator Dole made: Our bill includes major recommendations. It is a fairly comprehensive proposal that Senator Levin and I have submitted for the consideration of the Congress. We think it is going to take some time to consider and to determine what it is going to cost, what the revenue losses or gains might be.

We have suggested a temporary measure, however, and I have discussed this with Senator Dole and others. We need some sort of short-term relief as well.

There are two things that we have recommended that I believe are sensible to consider on the debt limit bill: One is to at least mandate that the Secretary of Health and Human Services at least take into account the caseloads with respect to the States. There are some States that have no backlog to speak of; there are others in which they are overloaded with cases to the point where they are just shoving the cases through, terminating them, taking them up on appeal. The Secretary ought to be mandated to make a review to see how they can slow down reconsideration of cases in those States where they are overburdened. It seems to me that you would thereby reduce the likelihood of unfair and unjust terminations.

Second, as a temporary measure we would recommend that we continue the payment of benefits through the administrative law judge level.

It seems to me if we would take those two measures, even though we would like to have the full comprehensive package considered, it would do a great deal in a very short time to relieve the pain that is being inflicted.

So those are the two recommendations I would make, Mr. Chairman—a short-term solution and the more comprehensive one that we have suggested.

[The prepared statement of Senator Cohen follows:]

STATEMENT OF
SENATOR WILLIAM S. COHEN
before the
SENATE FINANCE COMMITTEE

SOCIAL SECURITY DISABILITY REVIEWS

August 18, 1982

Mr. Chairman, I very much appreciate having this opportunity to testify on the Social Security Administration's continuing disability investigations.

As you are aware, the Social Security Administration, in response to a congressional mandate, has been reviewing the eligibility of hundreds of thousands of individuals with non-permanent disabilities. In my judgment, Congress was correct in mandating periodic reviews to identify those individuals who have recovered sufficiently to be able to resume working. The implementation of this law, however, has created chaos and inflicted pain that Congress neither envisioned nor desired when it enacted what was intended to be a sound management tool. The problem is not with the principle of the periodic reviews, but rather with the manner in which they are being conducted. And we in Congress share a large measure of responsibility for failing to establish specific guidelines for selecting the cases and conducting the investigations.

On May 25, Senator Levin and I held a hearing in our Governmental Affairs Oversight of Government Management Subcommittee to investigate numerous reports that truly disabled people from all over the country were having their benefits terminated as a result of the new reviews. What we found was most disturbing. Benefits were being discontinued in more than 40 per cent of the cases reviewed -- far above the 20 per cent rate originally predicted by the SSA itself. Yet, more than two-thirds of the claimants who appealed were eventually reinstated to the program after a hearing before an Administrative Law Judge. The tragedy is that, in waiting for reinstatement, these severely disabled persons and their families must go without benefits for many months -- or even a year -- due to the tremendous backlog of cases. Many individuals have been forced to turn to welfare because their disability benefits had been their only source of income.

Witnesses at our hearing recounted case after case in which truly disabled individuals lost their benefits and suffered financial hardship and emotional trauma because of an unjust system. I know that other witnesses today, including Senator Levin, will provide specific examples to the Committee, so I will not dwell on the desperate cases that our Subcommittee discovered.

We identified several problems with the continuing disability investigations:

(1) The SSA does not provide the claimants with an adequate notice explaining the gravity of the review and the beneficiaries' responsibilities. Instead, a highly misleading notice is provided which simply informs the claimant that his case is "under review" to determine if he "continues to meet" the requirements.

(2) No face-to-face interview is held with the claimant until the hearing before an Administrative Law Judge. This absence of personal contact gives the claims examiner an incomplete picture of the claimant's condition and reinforces the beneficiary's feeling of bureaucratic indifference.

(3) Decision-makers use different and, at times, conflicting standards to determine disability. The SSA criteria imposed on state claims examiners are not subject to public notice and comment.

(4) In a number of cases, the medical files which the claims examiners rely on are incomplete and lack current medical evidence from the treating physician.

(5) No presumption of validity is accorded the initial decision which entitled the claimant to receive benefits. Instead, as the General Accounting Office has said,a system of "zero-based eligibility" is used, in which the claimant must prove all over again that he is entitled to benefits.

(6) In a number of cases, individuals whose medical conditions have actually deteriorated since they started receiving benefits many years ago are having their benefits ended.

In short, our hearing revealed an disturbing pattern of misinformation, incomplete medical examinations, inadequately documented reviews, bureaucratic indifference, erroneous decisions, financial and emotional hardships, and an overburdened system.

Rectifying such fundamental deficiencies will require comprehensive legislation, such as Senator Levin and I introduced on June 24. Our bill, S. 2674, would shift the burden of proof from the disability recipient to the government to show why benefits should be discontinued; require a showing of medical improvement or evidence of working, fraud, or error before termination; impose uniform standards -- subject to public notice and review -- on all decision-makers; require state agencies to conduct a face-to-face interview with those individuals whose benefits are likely to be terminated; eliminate reconsideration by the state agency to shorten the appeals process; include a definition of pain in the statute; and continue benefits until a hearing is held before an Administrative Law Judge for those individuals who appeal the termination decisions.

It will take time for Congress to effect the needed changes in the disability review process. I believe, however, it is essential that we act to provide immediate relief to the thousands of disabled individuals whose benefits are being terminated and then reinstated by an ALJ, and to slow down the CDI process so that it may proceed at a more rational pace.

Our short-term solution, which we will offer as an amendment to the debt limit bill, has two parts. It would direct the Secretary of Health and Human Services to determine on a state-by-state basis the appropriate volume of reviews, and it would continue disability payments until the Administrative Law Judge stage of the appeals process. Both steps could be easily and quickly implemented.

Slowing down the number of cases reviewed would help both claimants and the state agencies which conduct the investigations. Currently, case files are literally overflowing out of boxes in some state offices, and unreasonable burdens have been placed on many state agencies, particularly in those states where personnel freezes have prevented the hiring of needed staff. By directing the Secretary to proceed with the reviews at a pace which recognizes the necessity for careful evaluations and a more even workload, our amendment would improve the quality of the decisions and lessen the backlog of appeals.

By continuing benefits pending appeal, our amendment would eliminate the needless financial burden now imposed on disabled people who are mistakenly removed from the program, despite being unable to resume work. Currently, claimants who are successful in appealing their termination decisions receive back benefits but only after months of disruption and delay. Our amendment would prevent the interruption of benefits which these individuals eventually would receive anyway.

Surely, when we are dealing with the most disabled workers in our society, we should enact every safeguard to insure that the government does not add another burden to the ones that they already must bear.

Mr. Chairman, I commend you for holding this hearing today, and I urge the Committee to act immediately to provide relief for disabled Americans who are victims of a faulty and unfair system.

Senator **Armstrong**. Senator Cohen, we are very grateful to you for that statement, and for the hearings you have held and the conclusions you have drawn. We appreciate that very much.

Senator Levin, I believe that you also participated in those hearings, and we are eager to hear your statement as well.

STATEMENT OF THE HONORABLE CARL LEVIN, U.S. SENATOR FROM THE STATE OF MICHIGAN

Senator **Levin**. Thank you, Mr. Chairman, and other members of the committee. We are grateful for what you are doing here today.

Mr. Chairman and other members of the committee, in November of 1981 Richard Kage, who was the 49-year-old former surveyor, died as the result of two massive heart attacks. He had been receiving disability benefits from Social Security since 1974, based on his diabetic condition and complicating factors such as loss of vision, hypertension, and arteriosclerosis. As a result of one of these CDI reviews—these Social Security reviews that Senator Cohen has described, initiated in response to the amendments which the Congress had adopted to the Social Security Act—he had been terminated from the disability payments in July 1981. He had requested reconsideration of that termination, and, tragically, he died before that redetermination was made. After it was made, he was reinstated post mortem.

His treating physician was so outraged by the manner in which the review of Mr. Kage's disability had been handled that he initiated, on his own, a letter to the Social Security Disability Office. I would like to read just a few lines from that letter:

"After being notified that he was now capable of working, and in the process of attempting to do so, and under the stress created by the termination of his disability benefits, Mr. Kage had an acute myocardial infarction and died." He said that the termination of Mr. Kage's disability "by a bureaucracy that can't possibly function in an honest and ethical fashion" is the greatest example of a miscarriage that he had ever seen. "I don't care who up there realizes that I feel this way; I will say it now, and I will say it publicly that this service is a disastrous failure."

I have another letter from a doctor, which he initiated, which I would also like to share with you. It is a copy of a letter addressed to President Reagan, a copy of which I received from a cardiologist with the Burns Medical Clinic in Petoskey, Mich., just dated in July of this year. It reads:

> Dear President Reagan: I am sitting in my office looking at a chest X-ray on a patient * * * who has severe heart disease and cannot walk over 25 feet without stopping to rest. This is just one of hundreds of cases that I am seeing on a daily basis in which the Social Security Administration Disability Determination Service has stopped disability payments, stating that these patients are no longer disabled.
>
> I would be more than happy to send you names and specific cases if you so desire, but I can only tell you that the trend over the past year has been one of total disregard for the well-being of all seriously disabled cardiac patients. The money wasted by the Social Security Administration to run through all this foolish paperwork is certainly much more than the meager amount of money they will save by putting these poor people in a state of serious destitution.
>
> I am sure this is not the first letter of complaint you have had on this subject. If you wish specific cases, names, and addresses, I will be more than happy to supply them.

These are remarkably strong words from two members of the medical profession who have observed firsthand the impact of CDI's on disabled individuals. They can't believe, we can't believe, I hope none of us can believe that a system that was designed to protect the members of our work force from the uncertainties of disabling disease or accident can now be so totally callous and inhumane.

Even before the commencement of these disability reviews the disability program was in a mess. Significant structural and managerial failings had been well documented in critical reports and investigations by various agencies of this Government.

The problem was exacerbated by the enormous number of reviews which the Social Security initiated in March of 1981, and just to give you some round figures: In 1980 there were 160,000 reviews; in 1981 that doubled to 357,000 reviews; in 1982 it tripled to 567,000 reviews; and in 1983 there will be 840,000 reviews.

These statistics in and of themselves are not disturbing, because that is exactly what we wanted—reviews. We want people off these rolls who don't belong there. I think the chairman has well said that.

I believe we want with equal passion that people who do deserve to be on those rolls stay on those rolls or get on those rolls. We should want both goals with equal determination.

More disturbing is the fact that although State agencies received 233 percent more cases for review by December of 1981 than they had a year before, and the number of pending cases climbed by over 368 percent, the number of disability examiners full time in the system rose only 29 percent. And of course the massive injustice is perhaps most starkly dramatized by the figures that Senator Cohen has given, which is that about half the people appeal the dismissals from the roll, and two-thirds of those appeals are reversed by administrative law judges, a two-thirds reversal rate. And given the present rate of reviews, if the present volume of reviews continue without changes, without procedural safeguards by this Congress, the Social Security Administration will have gone through the costly and unjust effort of terminating and subsequently reinstating a quarter of a million individuals who deserve to remain in the program by the end of 1983. A quarter of a million individuals will have been dismissed from this program and then reinstated about a year later after the appeal process has gone through, unless we make some changes, by the end of 1983.

Senator Cohen has described the components of our comprehensive reform bill, and I am not going to describe them in any detail; they will be part of my statement, which I assume will be made a part of the record. That is in Senate bill 2674. However, I would urge the members of this committee to support a temporary emergency amendment which Senator Cohen and I will be offering on the debt ceiling bill, and that is an amendment which is similar to Senate bill 2724 which we have introduced. That will do the two things which Senator Cohen outlined: It will on a temporary basis continue payments through the appeal process, the administrative law judge appeal process, only through 1983, to give us time for comprehensive reform. The other thing that it will do is slow down these reviews so that they are manageable at a State and local level and on appeal so that we will not have this terrible backlog that we have now seen in the review process.

I hope the members of this committee and others of our colleagues will support this emergency amendment on the debt-limit bill. I would ask that the testimony of Ethel Kage, who is the widow of the gentleman who died and whose doctor wrote as I quoted, will be made part of the record before this committee. Ethel Kage's testimony is courageous; it is eloquent testimony; and it is just one of a multitude of testimonies available to this committee which have caused so many Senators—not just Senator Cohen and I, but Senator Heinz, Senator Riegle, Senator Metzenbaum, Senator Kennedy, Senator Dole, and many others—to be involved in this effort to provide some relief. And it is that kind of testimony which has caused us to urgently request this committee to support some emergency relief and some comprehensive reform legislation.

Senator ARMSTRONG. I will be very happy to incorporate the material that you have requested in the record of this proceeding, and I want to thank you for your statement which was extraordinarily interesting, I'm sure to all on the committee and a very effective presentation. Thank you, Senator.

Senator LEVIN. Thank you, Mr. Chairman.

[The prepared statement of Senator Levin and attachments follow:]

STATEMENT OF SENATOR CARL LEVIN
SENATE FINANCE COMMITTEE
August 18, 1982
SOCIAL SECURITY DISABILITY REVIEWS

Mr. Chairman, on November 27, 1981, Richard Kage, a 49-year-old former surveyor, died as the result of two massive heart attacks. He had been receiving disability benefits from the Title II Social Security Disability Program since 1974, based on his diabetic condition and complicating factors such as loss of vision, hypertension and arteriosclerosis. As a result of a review of his condition -- or CDI as it is called -- initiated in response to the 1980 amendments to the Social Security Act requiring cases to be reviewed once every three years -- he was terminated from the disability program in July, 1981. He had requested reconsideration of that decision, but he died before it was made. He was, in fact, reinstated post mortem.

Mr. Kage's treating physician was so outraged by the manner in which the review of Mr. Kage's disability was handled, that he sent a letter to the Social Security disability office. I'd like to read that letter for the record. (Letter is attached.)

I have another letter from a doctor which I would like to share with you. It is a copy of a letter addressed to President Reagan which I received from a cardiologist with the Burns Medical Clinic in Petoskey, Michigan, dated July 15, 1982.

> "Dear President Reagan:
>
> I am sitting in my office looking at a chest x-ray on a patient whose heart is as large as they come. This man has severe heart disease and cannot walk over twenty-five feet without stopping to rest. This is just one of hundreds of cases that I am seeing on a daily basis, in which the Social Security Administration, Disability Determination Service has stopped Disability Payments, stating that these patients are no longer disabled ...
>
> "I would be more than happy to send you names and specific cases if you so desire, but I can only tell you that the trend over the past year has been one of total disregard for the well-being of all seriously disabled cardiac patients. The money wasted by the Social Security Administration to run through all this foolish paper work is certainly much more than the meager amount of money they will save by putting these poor people in a state of serious destitution.
>
> "I am sure that this is not the first letter of complaint that you have had on this subject. If you wish specific cases,names, and addresses, I will be more than happy to supply them."

These are remarkably strong words from two members of the medical profession who have observed firsthand the impact of the CDI's on disabled individuals. They are obviously fed up with the inequitable treatment given to truly disabled persons and through our hearings in the Oversight Subcommittee of Governmental Affairs, I've come to learn that a large number of people feel the same way. Basically, they can't believe that a system that was designed to protect the members of our workforce from the uncertainties of disabling disease or accident can now be so totally callous and inhumane.

The Social Security Disability program was enacted to protect this country's workers, to guarantee to employees that should they become the victim of a serious disability, that they would continue to receive a monthly income in partial place of the wages they were no longer able to earn.

The employees have paid for this benefit -- for this insurance -- for this peace of mind. But the way reviews that we mandated in 1980 have been carried out by the Social Security Administration, prematurely and callously,have made this promise a farce.

Even before the commencement of these continuing disability reviews, the disability program was in a mess. Significant structural and managerial failings had been well documented in critical reports and investigations by the House Ways and Means Committee, the General Accounting Office, the National Commission on Social Security, to name but a few. These problems included case overloads, unreasonable case processing and appeals delays, and confusion between state and federal decision-makers over the criteria for disability determinations.

Exacerbating these problems, of course, has been the enormous number of CDI's which Social Security has initiated in response to and anticipation of the mandate to review every case at least once every three years.

In 1979 and 1980, respectively, Social Security reviewed 160,000 cases for continuing disability. In 1981, the number arose abruptly, with little warning to state agencies, to 357,000. Social Security plans to review 567,000 cases in FY 1982 and 840,000 in FY 1983. I hasten to add that these cases are in addition to the 160,000 cases already reviewed by Social Security which will also continue. As a result, the total cases to be reviewed are even more startling: 727,000 in FY 82 and 1 million in FY 83.

More disturbing are statistics which reveal that Social Security has not been staffed sufficiently to handle the increased workload. State agencies received 233 percent more cases for review by December, 1981 than December, 1980, and the number of pending cases climbed 368 percent.

At the same time, the number of full time disability examiners in the system rose only 29 percent.

It is no surprise that delays have increased. The average number of cases pending before each administrative law judge (ALJ) was already 128 in 1978. By October, 1981, the number had risen by 50%. The number of cases awaiting an ALJ hearing totaled 126,000 in October, 1981, and two-thirds of all ALJ cases were not being processed within the 165-day limit previously imposed by a Federal court.

What is striking is the eventual outcome in the cases reviewed by a system struggling along so desperately. Between March 1981 and April 1982, Social Security reviewed 405,000 cases and nearly half, or 47 percent were dropped from the program, far exceeding the 10 percent estimate made by GAO or even Social Security's 20 percent prediction. Stark tragedy results from the fact that the terminations are massively unjust. The proof of that is that 67 percent, or two-thirds of the appeals to administrative law judges from those terminations result in reversals a year or so later -- a 67% reversal rate. Two-thirds of the people who appeal their cutoff are reinstated by administrative law judges a year later.

The saddest fact of all is that those people who have been unjustly terminated from the program suffer without their benefits and accompanying medicare coverage for the duration of the wait for the appeals decision, which takes 9 to 12 months. So, of the 109,000 persons whose benefits were terminated between March, 1981 and April, 1982, half of those persons will appeal the decision to an ALJ and 67% will be reinstated. That means that 36,000 people had to go without needed disability income for about a year when, in fact, they never should have been terminated in the first place.

An immense amount of unjustified, needless, unconscionable suffering takes place during that year. A number of suicides have even occurred as a result.

If the present volume of reviews continues, without procedural safeguards, the Social Security Administration will have gone through the costly and unjust effort of terminating,and subsequently reinstating 232,000 individuals who deserve to remain in the program, by the end of 1983.

In response to this situation, Congress must act. We can provide the desperately needed relief in two ways: First, we need to provide some immediate relief to those persons subject to reviews who may be unjustifiably terminated, and second, we need to comprehensively reform the entire disability review process. Senator Cohen and I have introduced legislation to do both.

S. 2674, our comprehensive reform bill, would do the following:

First, require that all standards and criteria for disability determinations be promulgated through notice and comment, made a part of Federal regulation, and be considered binding at all levels. Any internal Social Security instructions would be restricted to operations only and would not further define the substantive regulations.

Second, require in disability reviews that the Government specifically find that the person has medically improved to such an extent that the person is no longer disabled, or that the initial finding or eligibility was clearly erroneous, based on standards which were in effect at the time the initial decision was made.

Third, revise and streamline the procedure for disability decisions.

Fourth, include a clear definition of pain and its role in disability decisions.

Fifth, require the promulgation of regulations governing the use and purchase of consultative examinations, the weight to be given both evidence from consultative and treating physicians and the ways of monitoring the quality and quantity of consultative examinations.

S. 2725, the amendment Senator Cohen and I will be offering to the debt ceiling bill, will slow down the number of reviews to accommodate the number of available staff and the current CDI backlogs, and most important, will require through 1983 payment of benefits through the ALJ appeal stage. We believe that this will buy us sufficient time to pass comprehensive reform legislation.

I urge the committee to persist diligently in addressing the current problems in the Social Security disability program. They are real; their consequences are painful. And, I urge the support of the members of the committee for the emergency amendment Senator Cohen and I will be offering to the debt ceiling measure.

Finally, I will submit for the record, as part of my statement, the testimony of Ethel Kage, received before the Oversight Subcommittee, regarding her husband who died of diabetes and various complications shortly after he had been notified that he was, in fact, no longer disabled and was to be terminated from the disability program.
It is a moving and courageous account and I commend it to my colleagues.

As I have said at various times, no one wants individuals on the disability program who don't belong there. With equal passion, however, we do want those persons who are eligible for benefits to receive them.

I thank the Committee for this opportunity to testify and hope these hearings will become the catalyst for urgent temporary relief and for long-term comprehensive reform.

Drs. Vining, Townsend, Rood,
Van Tuinen, Dobbie, P.C.
Blodgett Professional Building
1900 Wealthy St., S.E.
Grand Rapids, Michigan 49506

Telephone 459-0292

February 8, 1982

Ms. Debra Flynn
Medical Relations Coordinator
Bureau of Rehabilitation
Disability Determination Service
P.O. Box 1200
Traverse City, MI 49684

RE: Mr. Richard Kage

Dear Ms Flynn:

Thank you for your letter relative Mr. Richard Kage. I think that it is appropriate and proper that his benefits be continued instead of eliminated. I will not review the factors involved in this case because I am sure your files contain the letters from me dealing with this situation.

However, I should like to correct one misconception that you apparently have and I think it is important for those you represent to be aware of the fact that Mr. Kage is no longer living. The treatment received by the Bureau of Rehabilitation Disability Determination Service to Mr. Kage's problems resulted in his attempt to try and work after being notified that he was now capable of working and in the process of attempting to do so and under the stress created by the termination of his disability benefits Mr. Kage had an acute myocardial infarction and died. I think the benefits that had been denied him prior to his death should certainly be provided to his widow who has worked very hard to take care of her husband.

As I have stated in previous correspondence and as I stated to Dr. Nesmith (who I know personally) this is probably the greatest example of a miscarriage of the termination of a disability determination by a bureaucracy that can't possibly function in an honest and ethical fashion. I don't care who up there realizes that I feel this way; I will say it now, and I will say it publicly that this service is a disastrous failure. At the same time Mr. Kage's disability was terminated another man in the same location (Reed City) was given disability pension who had no more license to receive it than the man in the moon; I know because I took care of him. His only disability was that he couldn't stop drinking or smoking and that is not a disability that should be compensated.

If you would like to ask me any more questions about this case and if you have anything by which you could alleviate my disdain for the Disability Determination Service I should be glad to hear from you.

Sincerely,

K. K. Vining Jr.

Keats K. Vining, Jr, M.D.

KKV/srs

STATEMENT OF ETHEL A. KAGE, REED CITY, MICH.

Mrs. KAGE. Yes.

First, I want to thank you, Mr. Chairman and Senators, for giving me this opportunity to come and share the personal experiences that we've had with the Social Security Administration and perhaps help in some small way to alleviate the situations which arose that caused us so much pain and suffering.

I'll start just briefly with my husband's history. He'd been on Social Security disability since 1974. Prior to that time, he'd been on insulin for a diabetic condition since he was 12 years old. For the past 15 years, prior to his death, he was taking four shots a day to effectively control that diabetes.

In the mid-1960's, the blood vessels in his left eye hemorrhaged, leaving him blind in his left eye. Shortly after that time, we became aware of a process, photocoagulation which fuses the blood vessels, and he had this performed on his right eye three times, until all the blood vessels were fused. Even after this process, it was a very touch-and-go situation because any sudden jolt would have severely damaged the eye. So, it was strictly a preventive measure, but not completely foolproof.

As I said, in 1974, he went on Social Security disability. This came about due to a stroke he had in May of 1974. He had come home from work. He was working approximately 70 miles from home at that time. He worked for the Michigan Department of Transportation on a survey crew. Friends had stopped over. When they left, he went out to bring our car around to hook up the trailer to go camping, and that's when it happened. He began honking the horn. I went out, and he was paralyzed on his right side, he could not see at all to speak of, and was confused, and his speech was slurred.

He entered the hospital for tests and observation. Of course, the diagnosis was he had had a stroke. By the next day, movement was restored in his right side. However, his vision was still impaired, to the point that he felt completely boxed in. Two days later that did—that feeling did leave him, but he still had tunnel vision. And that condition remained until he died.

Senator COHEN. Was he still partially paralyzed?

Mrs. KAGE. Pardon?

Senator COHEN. Was he paralyzed?

Mrs. KAGE. No. The paralysis left the following day.

We applied for and received Social Security disability without any problems whatsoever. In fact, it went through very speedily.

It's interesting, I think, to note that the same doctors who supported our disability claim at that time—the reports were accepted and taken into consideration on which, apparently, the disability was provided—when the reconsideration hearing came up, those same doctors were completely ignored, and apparently their reports were not taken into consideration at all.

In fact, Dr. Vining, who was the internist and diabetic specialist, who had been our doctor for some 17 to 20 years, states in his letter, which was written after Dick died:

"I believe that the disability determination service standards for disability are erroneous, false, and misleading.

"When a physician who has been entirely in charge of a patient's medical care states that a patient is totally disabled, it seems totally unrealistic and completely ridiculous for any physician seeing him one time on a brief examination to countermand a statement of disability on the part of an experienced physician on the basis of a single visual field determination. On Mr. Kage's residual vision, he was claimed to be no longer disabled and was directed to return to work by the Disability Determination Service."

I note with interest Senator Pryor's question on this very thing, whether the family physician's reports were considered or whether it was strictly for the government doctor. In our case, it was strictly the government doctor.

Senator COHEN. What did you do when you first got the notice? What process did you go through?

Mrs. KAGE. When we first received the notice of disability—it's called a Notice of Disability Examination Form. It merely states the Disability Determination Service has been asked to review our file, with the idea of elimination. At that time, they notified us that he had an appointment with an ophthalmologist in Mt. Pleasant, 45 to 50 miles from our home, and that the appointment—we had to confirm it, and it was up to us to get to that appointment. Otherwise, it would be considered that we were not interested in doing anything to refute this at all.

We did go. The doctor—Dick was probably with the doctor 15 to 20 minutes at the very most. And as his doctor said in his letter it was merely an eye-field vision exam.

The ophthalmologist in Grand Rapids, the doctor who had performed the photocoagulation, had written in his letter, copies of which had been sent to the Disability Determination Service—the bottom line that he wrote in his letter is that "This gentleman is in no condition for employment."

These two doctors, as I stated, were apparently completely ignored.

Senator COHEN. Let me ask you, did you go to your own physician, the one who had originally been treating your husband?

Mrs. KAGE. Yes.

Senator COHEN. And did you ask him to send in his reports?

Mrs. KAGE. I just read from that one, and also from the ophthalmologist's report.

Senator COHEN. Did you send them before the determination was made to deny your disability?

Mrs. KAGE. We sent that after we had received notice that they were examining our case and they had requested doctors' reports from our physicians. We obtained these and sent them on back up. The doctors sent them right directly to the Determination Service.

Senator COHEN. Were you under the impression that you would have to prove your husband's disability again?

Mrs. KAGE. No. That was never stated.

In fact, right up to this point, until I heard it today, I was not aware of that fact.

Senator COHEN. That they would disregard the prior condition?

Mrs. KAGE. Right.

And I think when we're talking about a review, we're talking about a misnomer, because a review is of something that has already been. What we're talking about here is John Doe walking in off the street is doing the same thing as a person who has been on disability, as Dick was for 7 years. And they have completely erased everything that happened prior.

Senator COHEN. Well, that's exactly why I raised that issue, because most people, when the SSA says your case is under review, normally would assume—well, from where?—from where you were, to see whether your case has improved or deteriorated, and start from there.

In fact, the practice has been to just ignore what the disability was, ignore past medical records, and take into account only from the moment where the claimant or your husband was examined by the doctor.

Mrs. KAGE. I would say up to that time I had not heard about that.

As I stated, he worked on a survey crew. He was statewide, so he traveled all over the State of Michigan. Even after he lost the sight of his left eye, he maintained that job, although it was rather difficult for him. After he had his stroke, with tunnel vision, of course, he was unable to drive. He could not do anything. If he were sitting here, he would not be able to see this pitcher of water here. This had not changed; this remained the same. When they reviewed our case, he was exactly the same as he had been several years prior when it was first granted to us.

Senator COHEN. How old was he at that time?

Mrs. KAGE. When he first went on disability, Social Security disability? He would have been 42.

Senator COHEN. And when was it? 1981—was that 10 years later? When did he go on?

Mrs. KAGE. 1974. When we received the Notice of Review, it was quite a shocking affair for Dick. I arrived home from work, and he was in a very agitated state. He thought everything, you know, was going down the drain, that the plug had been pulled out. He didn't know how we would survive.

I think our first thought at that time is what kind of a system is this that can allow something like this to happen? If we had the system for 25 years or so, why all of sudden are we going through this massive review? Isn't this something that should have been done on a continuing basis?

I grant you there are people who are on disability who do not belong there. And I personally know of some. However, this massive pinpointing now—why not over the years, in a systematic way? This has not been done.

We were on for 7 years and never any indication. At the end of the year we had to send in a report whether he had made any money that year from employment. And that's the only thing which we sent in every year.

Senator COHEN. Your husband was what, 50, when he died?

Mrs. KAGE. 49.

Senator COHEN. He had arteriosclerosis?

He was a diabetic since the age of 12? He was still on insulin, I assume, all that time?

Mrs. **Kage**. Un-huh.

Senator **Cohen**. Plus the determination made about his tunnel vision, he also suffered from hypertension?

Mrs. **Kage**. Yes. This was all presented to the Disability Determination Service on their review case. As I say, he was completely agitated and remained so; although I think, for the sake of the rest of us, he tried not to let it show.

Senator **Cohen**. I understand the SSA did, after Senator Levin's office intervened, at least restore the payments from the time they were denied up until your husband's death.

Mrs. **Kage**. Yes. I think the time frame is most interesting, in that we received the Notice of Disability Examination form on April 21. We received the Notice of Pending Cessation form on May 14, saying that they were advising the Social Security Administration to cease payments within the 2-month frame. We heard nothing from the Social Security Administration itself until July 30, saying they were discontinuing our payments with the July payment. We had no previous notice from the Social Security Administration that they were accepting the report of the Disability Determination Service.

On August 10, I sent the reexamination request in. On September 25, I sent additional data in from the doctors to support our claim.

On October 8, I called the Social Security office in Mt. Pleasant to find out—we had heard nothing—that they had received our request or anything at that time. Mrs. Wilson, in that office, said she would return my call after checking the file. I never received a call.

A week later, I then called the Social Security office, and she said they had requested the file from Baltimore and as soon as it was received she would sent it to Traverse City. She sent us additional forms that we needed to sign. I signed them and sent them back.

On October 30, I again called the regional office and asked what the status was, because we still had heard nothing. And she reported that the files had not been sent out from Baltimore. It was tied up in their computer process somehow, and they did not get the file.

All this time, we had been without any income. And at that time, Dick had been in the hospital. He had a toe that was gangrenous, and they thought it was going to have to come off. Fortunately, antibiotics stopped it at that time, so he only spent a week's stay in there.

I sent that additional information, also, to the Social Security Administration. By November 5, I still had heard nothing. That is when I contacted Senator Levin and our representatives for our district.

On November 25 then, we received another Notice of Disability Examination form from the Disability Determination Service in Traverse City, setting another appointment with the same doctor in Mt. Pleasant for another visual exam that we had gone through before.

Two days after that, Dick died. He took sick on Thanksgiving evening, and by 7 p.m. the next day he was dead. He had two massive heart attacks.

I talked to the doctor on Monday following the autopsy. He gave me the results. And the document was printed out. And he said at that time that the pressures that he sustained, the stress from this cessation of benefits, was definitely a contributing factor to his death.

I called the Disability Determination Service to tell them that we would not be keeping the appointment and why, that Dick had died. And they made no comment whatsoever. They just said, "All right," and hung up.

I think I would like to speak to that, because any time people are working with people and trying to be helping people, I think there could be a little compassion shown.

Through Senator Levin's work on our behalf, we received a letter from him and a phone call at the end of January saying that our Social Security disability was being reinstated from the time that it was cut off until Dick's death. This was on January 29. We received nothing from the Social Security Disability Determination or anyone else until April 5.

Senator **Cohen**. Of this year?

Mrs. **Kage**. Of this year. Never did we receive anything that they had received the file, that they were working on the file, other than my phone calls to Mt. Pleasant, never anything that was instigated on their part, no correspondence saying "We have received your request and it is being processed." We got nothing.

Senator COHEN. Mrs. Kage, one of the reasons I suggested that perhaps it would be a wise policy to have a face-to-face interview at the very initial stage is to try and deal with that very problem. It's something that's larger—and I mean this in a very sympathetic way—it's larger than your case. When the Social Security Administration talks about us as a society, we've moved to the age of the computer. All we have to do is just factor in the age, benefits, when they began, entitlements, push a button, and out comes a sheet. And that's not good enough. Then, they do the same thing, and they say, "Here are 40 cases or 440,000 cases. Now, we're going to determine how many people should be continued and how many should be discontinued." Again, there's no face-to-face dealing with those people.

You look at the file and you look at the docket report. The docket report may conflict with the one which you began, but you never see the person. And in an effort to insulate the hearing examiner from the passions of the people, from—I guess the way it was phrased—the emotion, to make an emotional determination is the very process by which we continue to calcify our indifference. We just remove people from the process and deal with it on a file-by-file, number-by-number basis. And that's what happens. People like you and your husband fall through the cracks in the computer. That's what happens.

So, I think it makes a good deal of sense to try and have that initial face-to-face meeting on the first meeting, not on reconsideration, but up front, the first time, so that we have some connection that I'm dealing with you as a person and not simply as a number

So, I would disagree with the proposal that we put it one step higher. We've already gone one step. We should start and make it at the very beginning. That's where the face-to-face determination ought to be, especially in a denial case.

I understand the administrative load which could be created. But in those cases, when you take something away that someday has, there ought to be some kind of a face-to-face determination to make that assessment. Otherwise, most people will be treated the same way, because the system, the way in which it was designed, it's a large, loaded bureaucracy, like we have here in Congress. We don't deal face-to-face with people.

So, I hope that we can make some changes and will learn from your experience.

Mrs. KAGE. I guess the main question I have is why they disregard the physician who has treated someone for X number of years and two experienced physicians—very well qualified physicians, specialists in their field—why these are completely ignored and the doctor who sees a person for 15 minutes can make the determination that he is no longer disabled, and everything rests on that doctor. So from our own personal experience, I would have to fault the Social Security Administration on their response to Senator Pryor's question concerning family physicians or their own physicians, because it's been our experience that the family physicians, even though they were specialists in their field, were completely ignored and a 15-minute exam by the government physician is the one that is considered.

If you have any more questions, I'll do anything I can. Our family survived by the grace of God, and it was through our faith and the presence of the holy spirit that we were able to maintain, and I think perhaps that's why I'm here today, because as I say, anything that anybody can do, they certainly should speak up and do.

Senator COHEN. You're been a very fine witness, and we appreciate your coming and discussing this as you have. I think a lesson can be learned by all of us. That's one reason that we asked that the members of the Social Security Administration be here and listen to you so they can learn from the mistakes that were made in the past.

One brief comment about something Senator Levin has touched upon with some very eloquent words that he offered, and this is: What is the nature of the relationship between the citizens and the government?

You find out it's adversarial in nature, or quasi-adversarial, as a legal term. In workman's compensation cases you have a similar situation with the claimant who claimed that he injured his back in the workplace, and he would go before a workman's compensation board and the insurance company always had its doctor, and all that insurance company doctor did was work for the insurance company. He spent 10 or 15 minutes being reviewed in these periodic reviews, and the burden would be upon the employer to show that that person's condition had changed, so you'd have to go and be examined by that company's doctor, the insurance company's doctor. But at least you had an opportunity to have your family physician say, "I've treated this person over the years," and usually the workman's compensation rules gave greater weight to someone who has treated somebody, a doctor who has treated somebody over a period of time, than they do to an insurance company doctor who has seen him for a few minutes.

But you understand at least the term, you understand the nature of the relationship when you are going in. It's the workman against the company. It's an adversarial process, which you don't expect. That's why I think it's so important that the letter to you be very clear about what you're up against, and what you've got to do is to prove your case. The burden is going to be upon you, and you'd better come prepared. And that letter doesn't do it.

That letter says your case is under review to see whether or not you're entitled to continue under the program. That, to me, conveys an entirely different relationships. So I think the first thing we ought to do is to be more candid, even at the risk of terrifying you, even at the risk of causing you anxiety. You ought to be informed, so you can be better prepared.

Second, I would hope that it wouldn't be as adversarial as we have seen it to be, and that what Senator Levin was saying about having some passion in favor of people as opposed to simply denying them would apply, and maybe that will come out of the same——

Mrs. KAGE. I would like to say that when the Social Security Administration says they don't want to terrify people, I think they're demeaning the public out there. When you receive a letter—if you receive a letter saying what was going to be done, how it was going to be done, I think that's an insult to my intelligence anyway, that I will be terrified by a letter saying how they were going to do something. I really take offense at that personally, because I think it's a very demeaning statement on their part, that the general public out there are just a bunch of slobs who, you know, have to be kept in the dark. And I find that very belittling.

Senator COHEN. Senator Levin?

Senator LEVIN. First of all, Mrs. Kage, I add my thanks to those of Senator Cohen for coming today. You've been a tremendous witness. You've gone through a lot of suffering, and it's important that you share that so that others can avoid what you had to go through, and we thank you for that.

Second, the files of the Social Security Administration confirm everything that you've said. We won't have to press you too much on details.

Third, let me just expand a bit on what Senator Cohen has just said, what he's pursued this morning in terms of that original letter, pointing out that that original letter doesn't tell you what is happening to you, and indeed it doesn't. It keeps you in the dark, as you have just said. It treats you like a child, to your own detriment, becauase ultimately what's happening to you is that you're in the process of being cut off the rolls. You're to be considered no longer disabled, in a vast number of cases without any adequate medical examination. That was what was happening to you. What's also happening is that you're going to have to prove all over again that you're disabled, and you're not told that, as Senator Cohen has pointed out.

Now, what's also happening, not only are you not told that you're going to have to prove all over again that you're disabled, but what also happens is that you're going to have to prove it according to new rules. The game is being played not according to the rules that were being played at the time of the disability determination, but according to new rules, and that's fundamental unfairness as well.

Finally, after all that is done to you without adequate knowledge, you may then appeal, and most of the people who are wise enough or informed enough or whatever to appeal, or are alive to appeal, are going to win. But during that 9 to 12-month period of that appeal, they're going to lose and they're going to lose hard because they're going to be cut off the rolls and benefits will not be paid during that period of appeal, although two thirds of the people appealing are going to win.

I can't get that fact out of my craw. No government, it seems to me, should tolerate that kind of injustice. It's a massive injustice.

What happened in your husband's case now, according to the doctor, it seems to me, is overwhelming, and I want to just read that line, although it hurts. I'm not a doctor, but let me read what a doctor said, and doctors don't say things like this very easily. He says, after your husand was notified that he was now capable of working and in the process of attempting to do so, and under the stress created by the termination of his disability benefits, Mr. Kage had an acute myocardial infarction and died.

Now, I've seen a lot of doctors in a lot of courts and know doctors do avoid testimony about causation. They do not readily reach those kind of conclusions. This is a conclusion which the doctor wrote in a letter to the Disability Determination Service, which should be made part of the record as to exactly what it is we're talking about in one case. Multiply this by hundreds of thousands of cases and we have an added dimension; but in one very real case, most real to you, you're familiar with it, we have a doctor that said that under the stress created by the termination of his disability benefits and attempting to work because he was totally incapable, he had a heart at acl and died.

One other—this doctor says, and his rage comes through the letter not as well as it would in person, but my gosh, he said in one letter here, if I can quickly find it, he says the termination of the disability determination by a bureaucracy that can't possibly function in an honest and ethical function, as he put it, is obviously disturbing to him. And then he said, "I don't care who up there realizes that I feel this way. I will say it now and I will say it publicly, that this service is a disasterous failure. I don't care who up there knows it."

Mrs. **Kage**. He was very frustrated. He'd been very supportive through our whole process. In fact, I'm not certain whether it was in that letter or the other letter that you have a copy of that he wrote to the determination service asking them to call him or contact him if they had any questions or if he wanted anything further that he could do, and he had never received any call from them, any correspondence from them. I talked to him just before I came to Washington.

Senator **Levin**. I think these letters should be made part of the record, not just as to what they say as to a specific case, but also because of the zrustration and rage that's reflected in here by a physician.

Again, people are on these rolls who shouldn't be there. I don't think we can defend sloppiness. But the way to cure sloppiness is not through the imposition of massive injustice and that's what we've done, and that's what we've got to stop. We want to get people off the rolls who don't belong on the rolls, but with equal fervor, we want people on those rolls who do belong. That's the purpose of the system, and your being here today is a very eloquent example of a system that's gone haywire, and again we thank you.

Mrs. **Kage**. As I said before, I'm just happy that I was able to do it, any small thing that I could. And one small item about the loss of benefits, during the appeal process the people who are on disability aren't making that much money that you can set money aside, that you have any kind of savings or income to support you over that time limit. So when your disability is discontinued, you're at the edge. I mean, you have nothing to fall back on to hold you over those months that it takes, and I think that is never taken into consideration. There is no leeway. When you're at the end, you're at the end, period.

Senator **Levin**. By the way, would your husband have liked to have worked if he could?

Mrs. **Kage**. Would he have liked to have worked? Very definitely. He sat home for 7 years and being confined, I mean, he couldn't even walk down the road because he would not have been able to see cars coming.

Senator **Levin**. Did it hurt him that he couldn't work?

Mrs. **Kage**. Did it hurt him?

Senator **Levin**. That he could not work.

Mrs. **Kage**. Yes, it was very frustrating to him. It was frustrating to him that he couldn't do—well, he just couldn't walk by himself, you know. If we would go shopping in malls or anything, we would have to walk one on each side of him because he was terrified that a little kid was going to run in front of him, a small child, and he would not be able to see him, you know, and knock him down or something.

Senator **Levin**. Thank you.

Senator **Cohen**. Thank you very much, Mrs. Kage.

Senator **Armstrong**. Our next witness is our colleague from Ohio, Senator Metzenbaum.

Senator **Metzenbaum**. I thank you. I will defer to Senator Riegle.

Senator **Armstrong**. I will be pleased to recognize our colleague from Michigan.

Senator **Riegle**. I thank my colleague from Ohio.

Senator **Armstrong**. If you will hold for just a moment, I see that Senator Dole is here.

Senator **Dole**. As I understand Senator Cohen and Senator Levin, they have a different proposal. Unless there are questions of them, we might excuse them. I know they have other things to do.

We appreciate your testimony. I hope we can work out something that might accommodate the various points of view on a temporary basis and then, with some more time, try to resolve the DI problems on a long-term basis. What we will do is follow up this hearing with representatives of various agencies involved to see if we can't find some common ground.

I don't know the schedule on the debt limit—I think it is going to be around for a while. I know the debt is going to be around for a while, but the particular debt extension will be around at least until after the recess. Hopefully during the recess we would have some time to focus on this. Perhaps if you don't offer your amendment until after that time we might be able to work out some agreement.

Senator LEVIN. Thank you.

Senator CHAFEE. Mr. Chairman?

Senator ARMSTRONG. Senator Chafee.

Senator CHAFEE. In Senator Levin's testimony did I hear him say that only 50 percent appealed? What did you say? Have I got that correct?

Senator LEVIN. My understanding is that approximately 50 percent of the people who are dismissed from the rolls appeal.

Senator CHAFEE. And of that 50 percent, two-thirds were reinstated?

Senator LEVIN. That is correct.

Senator CHAFEE. I see.

Senator LEVIN. We do not have statistics as to the reasons that the other 50 percent dismissed do not, as to whether they do not think they can get reinstated or they are satisfied with the result or that they agree with it—we do not know all of the grounds that might exist for not appealing. I don't think it would be fair to read into that necessarily that 50 percent should not have been there to begin with; there are many reasons for not appealing these decisions.

Senator CHAFEE. Fine. Thank you very much.

Senator COHEN. If I could just make one point. This case involving Mr. Kage I think is particularly important to look at, because here we have a man who was a diabetic from the age of 12, who went blind in one eye and lost half the vision in his remaining eye, and for all practical purposes could not perform any work at all. He had two physicians who stated that, but he was required to go to an ophthalmologist 45 miles from his home for a consultative examination that lasted 15 minutes. The ophthalmologist issued a report, from which I would like to read two or three lines.

The ophthalmologist issued a report which noted that Mr. Kage could detect some motion in his right eye, and concluded that "the patient is almost blind for all practical purposes, but the presence of central vision in the right eye gives him some reprieve from being a total cripple." Based upon that statement in his record they terminated his benefits at that point, notwithstanding all the past history.

So perhaps this is one of the more extreme cases; but when you start dealing with people through computers and paperwork and the bureaucratic maze, these kinds of cases are inevitable. The ultimate irony, as Senator Levin pointed out, is that after having gone through the appellate process, his benefits were restored after his death. Mr. Kage had to go into the hospital, as a matter of fact, to have a toe amputated because he had gangrene in his foot. He was released and then went back in and had two heart attacks. Then, after months of Mrs. Kage dealing with Senator Levin's office, the SSA reinstated the benefits about 6 or 7 months later, as I recall, saying an error had perhaps been made.

So it is because of the procedure—the goals are correct but it is the procedures which are inadequate—that you see a number of cases like this.

Senator ARMSTRONG. We very much appreciate those observations. And while the committee will understand if you can't stay, if your schedule permits please come up and join us at this table and hear the rest of the witnesses, or ask your staff to do so if that is more convenient for you.

Senator COHEN. Thank you, Senator.

Senator ARMSTRONG. Senator Riegle?

STATEMENT OF THE HONORABLE DONALD W. RIEGLE, JR., U.S. SENATOR FROM THE STATE OF MICHIGAN

Senator RIEGLE. Thank you, Mr. Chairman.

I think the testimony which you have just heard and the fine work that has been done by both Senators Cohen and Levin in their investigation, I think, are a very important part of the record here.

Clearly, this is an urgent problem, and I think this is a wretched, heartbreaking situation. It seems to me there are always appeals, but it takes more. We have known about this problem for months, and months, and months, and frankly, the Congress has not acted. We are not in a position to act now in terms of an immediate response, short of having to offer amendments to legislation on the floor.

So I think it is fair to say that it is not easy to solve this in a perfect fashion; on the other hand, we have made very little progress so far, and I am troubled about it. What has happened here is that there is a group of people who have been targeted in this country. The body of people we are talking about here are the people in our society least able to cope with things anyway and least able to respond to this situation. I suspect that half of the people who haven't appealed either are so frightened they don't understand the appeal process or hear that they may not have money for lawyers, and so forth, that they may just not be in a position to be able to even assess how they might fight back. But to have this group in our society who are people who are least advantaged, people who clearly have, in most instances at least, very severe medical problems, be under this terrific pressure, and to have us come back and say, "Well, you know, we would like to respond but the wheels turn slowly here and we just can't get an answer"—

I recall a time several years ago, and I'm sure Senator Dole will remember it, when there was a football game here in Washington, D.C. that was a sellout. I think the Redskins were playing if not for the championship it was one of the games that was the equivalent of that. It took a change in Federal law to enable that television game to be televised that week. But when it finally dawned on everybody that that had to happen, I never saw the wheels of Congress turn so quickly, and the whole thing basically got done within a week's time. It passed the House, passed the Senate, got to the President's desk—it was deemed to be important enough that we really saw action. So things don't have to move at a snail's pace around here; we can move quickly.

I must say, Senator Dole, and I say this respectfully in every way: I think that the job you have done on the tax bill has been acknowledged by everybody to be a feat of terrific personal leadership as a committee chairman and as a person trying to respond to a difficult problem, and so forth. The wheels have turned quite rapidly, and I think that is generally acknowledged.

I would hope that we could do the same here. We have folks out here in desperate shape who are waiting for us to respond, and we have an obligation to respond. I am convinced we can do it. We may not be able to do each and every part right now, but there are two or three basic things I think we can do immediately that I think are sound and are warranted in light of the record that has already been developed.

I have introduced a bill that is before you, S. 2776—cosponsored by Senator Metzenbaum, who is here, and Senators Kennedy, Burdick, Inouye, Cannon, and Pell, and I hope to be able to announce additional cosponsors soon—that would do three things on an immediate basis to get at least at a major part of this problem:

(1) The benefits would be continued until a final determination is made by an administrative law judge. I have heard Senator Levin and Senator Cohen urge the same thing.

(2) The bill would also slow down the number of disability reviews now occurring to a level that would be consistent with what the disability examiners can manage, because clearly we are forcing a greater volume through the pipeline than we are capable of handling from an administrative point of view. I don't think that is sound, I don't think it is sensible, and I think it is wretchedly unfair.

(3) Finally, and perhaps most important, the bill would require evidence of medical improvement for purposes of terminating benefits. In other words, this would be an affirmative requirement on the part of the Government to have in hand documentary evidence that shows that the disability that had previously been thought sufficient for benefits no longer applies. I think this provision is critical if we are to seriously confront the significant reversal rates that have been mentioned—something on the order of 67 percent—that we are seeing with those folks who go through the appeals process.

I think placing the burden of proof on the Social Security Administration to demonstrate that the beneficiary has actually medically improved would significantly reduce the number of cases where there is an initial termination decision which is later reversed on appeal.

I want to just give you quickly in summary a couple of other illustrations. I don't know that Michigan is any harder hit than the other States, but you have heard from Senator Levin and Senator Cohen cases from Michigan. I would like to give you a couple of others.

We have had persons be compelled to take a stress test with serious heart conditions, where you have to go in and, as you know, go through the treadmill test, which is being used as the only authorized test for medically validating the existence of certain types of heart conditions. We have had people who were so ill and whose heart conditions were so severe that their doctors had said that they would not give them the stress test because those tests would kill them, literally; that they have every reason to believe they would not survive a stress test because it would just take them beyond their physical limits.

I will relate to you one specific case here. It was only after the caseworkers in my office were able to convince supervisory personnel in the State disability office to contact this particular person's doctor and to examine other available medical evidence that we were able to prevent the termination of benefits in that particular case. But I don't know how many other cases there are like this around that we have not heard about, that have not come to us or may be in some other area.

Finally, on the issue of suicides, we have had those occur in the State of Michigan. We had one man who became so despondent after being taken off disability—clearly with very severe medical problems, unable to work, unable to support his family—he became so distraught that he went down in front of the Social Security Office in Lansing, Mich. and shot himself to death. This was a case that received some national attention as the result of the facts in that particular case, but there are others like that that are not getting into the news.

We have learned of an elderly woman living alone in a house trailer who also was removed from the disability rolls, unable to support herself, despondent, who set fire to her house trailer and died in that fire. And I just know that there are any number of other cases like this going on.

But those who are not driven to that extreme measure of despair are worried sick. They are out there, sick to start with, and absolutely desperately afraid of what is taking place here and not knowing how to respond to it.

We act on a lot of things around here. We solve a lot of problems—we have legislation up now, we are acting in the Banking Committee on banking legislation over the next couple of days—and this is something we can do something about. I don't think it should wait until the next session of Congress; I think we ought to get it done this year. I think we ought to pledge ourselves to get it done, and I think we can. Whether it be the bill that I have submitted with my cosponsors or whether it be the legislation that others have offered, whether we do it in terms of amendments to the debt limit bill or something else, let's do something now. Let's respond to this problem. We know it is severe, and there is every reason in the world to respond and no good reason not to.

I thank you.

[The prepared statement Senator Riegle follows:]

SENATOR DONALD W. RIEGLE, JR.

STATEMENT ON SOCIAL SECURITY DISABILITY CONTINUING DISABILITY INVESTIGATIONS

MR. CHAIRMAN AND OTHER MEMBERS OF THE COMMITTEE, I DEEPLY APPRECIATE HAVING THIS OPPORTUNITY TO TESTIFY BEFORE THE COMMITTEE ON FINANCE ON THE IMPORTANT ISSUE OF SOCIAL SECURITY CONTINUING DISABILITY INVESTIGATIONS (CDIs). IN MARCH OF THIS YEAR I TESTIFIED IN FRONT OF THE HOUSE SUBCOMMITTEE ON SOCIAL SECURITY, COMMITTEE ON WAYS AND MEANS, WHICH AT THE TIME WAS CONSIDERING COMPREHENSIVE LEGISLATION DESIGNED TO ADDRESS THE SERIOUS PROBLEMS EXPERIENCED IN THE SOCIAL SECURITY DISABILITY PROGRAM. THE BILL UNDER CONSIDERATION IN THE HOUSE AT THAT TIME, H.R. 5700, LATER MODIFIED AND RE-NUMBERED AS H.R. 6181, WAS REPORTED ON MAY 26, 1982, AND HAS NOT RECEIVED FURTHER CONSIDERATION IN THE HOUSE SINCE THAT DATE.

THE PROBLEMS ASSOCIATED WITH THE DISABILITY INVESTIGATIONS HAVE NOT GONE AWAY. THE UNNECESSARY AND UNINTENDED SUFFERING EXPERIENCED BY HUNDREDS OF THOUSANDS OF SOCIAL SECURITY DISABILITY BENEFICIARIES HAS NOT GONE AWAY. THIS EXTREME, AND IN MOST INSTANCES SENSELESS SUFFERING HAS NOT GONE UNNOTICED BY CONGRESS YET WE HAVE FAILED TO ENACT LEGISLATION DEALING WITH THIS SERIOUS PROBLEM. IN ADDITION TO THE EVIDENCE GATHERED BY THE WAYS AND MEANS SUBCOMMITTEE ON SOCIAL SECURITY, THE HOUSE SELECT COMMITTEE ON AGING HELD SEVERAL DAYS OF HEARINGS AS DID THE GENERAL OVERSIGHT AND GOVERNMENT MANAGEMENT SUBCOMMITTEE OF THE SENATE COMMITTEE ON GOVERNMENTAL AFFAIRS. I BELIEVE THE

DOCUMENTATION OF SERIOUS PROBLEMS WITHIN THE DISABILITY PROGRAM IS UNEQUIVOCAL. I BELIEVE WE HAVE A CRISIS ON OUR HANDS THAT DEMANDS IMMEDIATE ATTENTION.

CONGRESS FIRST ENACTED THE AMENDMENTS TO THE SOCIAL SECURITY ACT IN 1980 BECAUSE NO ONE WANTED TO SEE INDIVIDUALS WHO HAD MEDICALLY RECOVERED OR WHO HAD RETURNED TO SUBSTANTIAL EMPLOYMENT CONTINUE TO RECEIVE BENEFITS IN VIOLATION OF FEDERAL LAW. THE RAPID EXPANSION OF THE SOCIAL SECURITY DISABILITY INSURANCE PROGRAMS DURING THE NINETEEN SEVENTIES TOGETHER WITH PROJECTED SHORTFALLS IN THE DISABILITY INSURANCE TRUST FUNDS, MADE THE TIGHTENING OF THE ADMINISTRATION OF THE PROGRAM NECESSARY. NOW, GIVEN THE CURRENT FINANCIAL STATUS OF THE SOCIAL SECURITY SYSTEM WE MUST VIGILANTLY SEEK OUT INDIVIDUALS WHO ARE NOT DESERVING OF BENEFITS. HOWEVER, CONGRESS DID NOT ENVISION NOR CAN WE ALLOW THE CONTINUED ANGUISH AND TORMENT OF OUR DISABLED CITIZENS.

FOR THESE REASONS AND OTHERS, I INTRODUCED ON JULY 26, 1982, S. 2776, COSPONSORED BY SENATORS KENNEDY, METZENBAUM, BURDICK, INOUYE, CANNON, AND PELL, WHICH I CONSIDER EMERGENCY LEGISLATION DESIGNED TO EASE THE UNNECESSARY SUFFERING EXPERIENCED BY HUNDREDS OF THOUSANDS OF DISABLED AMERICANS. THIS BILL WAS DEVELOPED BY A BROADBASED COALITION OF GROUPS CONCERNED WITH THE NEEDS OF DISABLED AMERICANS. THE PROPOSAL CONTAINS SELECTED PROVISIONS FROM SEVERAL OTHER BILLS, MANY OF WHICH I ALSO COSPONSORED, DESIGNED TO HALT THE WRONGFUL TERMINATION OF DISABILITY BENEFICIARIES UNTIL CONGRESS IS ABLE TO DEVELOP

A MORE COMPREHENSIVE SOLUTION.

I WOULD LIKE TO BRIEFLY OUTLINE THE THREE PROVISIONS CONTAINED IN MY BILL WHICH I BELIEVE ARE THE THREE MINIMUM REQUIREMENTS NECESSARY TO CORRECT THE SITUATION UNTIL A BROADER, MORE THOROUGH SOLUTION CAN BE DEVELOPED.

FIRST, MY BILL WOULD REQUIRE THAT BENEFITS BE CONTINUED TO BE PAID UNTIL A FINAL DETERMINATION HAS BEEN MADE BY AN ADMINISTRATIVE LAW JUDGE. IF AT THIS POINT IN THE APPEALS PROCESS THE BENEFICIARY IS DETERMINED TO BE NO LONGER DISABLED UNDER LAW, THEN THOSE PAYMENTS RECEIVED DURING THE APPEALS WOULD BE CONSIDERED OVERPAYMENTS AND SUBJECT TO RECOUPMENT. THIS WOULD STOP THE CURRENT SITUATION WHERE DISABLED BENEFICIARIES FACE THE ABRUPT TERMINATION OF THEIR BENEFITS ONLY TO HAVE THOSE BENEFITS REINSTATED AFTER MANY MONTHS OF UNDUE SUFFERING AND HARDHSIP. ONLY THOSE INDIVIDUALS WHO CONTINUE TO BE DISABLED UNDER LAW WOULD BENEFIT FROM THIS PROVISION.

SECONDLY, MY BILL WOULD SLOW DOWN THE NUMBER OF THE DISABLITY REVIEWS WHICH ARE CURRENTLY AT A LEVEL GREATER THAN THAT WHICH CAN BE HANDLED BY THE PRESENT NUMBER OF DISABILITY EXAMINERS. NO ONE IS MORE CONCERNED ABOUT THIS ISSUE THAN THE DISABILITY EXAMINERS IN MY STATE OF MICHIGAN WHO AS INDIVIDUALS ARE IN A UNIQUE POSITION TO UNDERSTAND THE DIFFICULTIES CREATED AS A RESULT OF THE MANDATED REVIEW REQUIREMENT ENACTED

AS PART OF THE 1980 SOCIAL SECURITY DISABILITY AMENDMENTS. AT THIS POINT I ASK THAT A LETTER TOGETHER WITH AN ANALYSIS OF THE DISABILITY REVIEWS BY THE MICHIGAN ASSOCIATION OF DISABILITY EXAMINERS BE INCLUDED AS PART OF THE HEARING RECORD.

FINALLY, AND PERHAPS MOST IMPORTANTLY, MY BILL WOULD REQUIRE EVIDENCE OF MEDICAL IMPROVEMENT FOR PURPOSES OF TERMINATING BENEFITS. THIS PROVISION IS CRITICAL IF WE ARE TO SERIOUSLY CONFRONT THE SIGNIFICANT REVERSAL RATES WE ARE SEEING IN CASES WHERE THE INDIVIDUAL APPEALS THE TERMINATION DECISION. RECENT DATA INDICATES AS MANY AS TWO-THIRDS OF THOSE INDIVIDUALS WHO APPEAL ARE LATER REINSTATED BACK ON THE DISABILITY ROLLS. FOR MANY OF THESE INDIVIDUALS THEIR DISABLING CONDITIONS HAVE NOT CHANGED AND SOME HAVE ACTUALLY PROGRESSED. BUT DUE TO CHANGES IN THE CRITERIA USED FOR DETERMINING DISABILITY AND DUE TO THE USE OF DIFFERENT CRITERIA AT VARIOUS LEVELS OF APPEAL, MANY INDIVIDUALS WHO REMAIN SEVERELY DISABLED ARE BEING THROWN OFF OF THE DISABILITY ROLLS. BY PLACING THE BURDEN OF PROOF ON THE SOCAIL SECURITY ADMINISTRATION TO DEMONSTRATE THAT THE BENEFICIARY HAS ACTUALLY MEDICALLY IMPROVED, I BELIEVE WE WOULD SIGNIFICANTLY REDUCE THE NUMBER OF CASES WERE THE INITIAL TERMINATION DECISION IS REVERSED ON APPEAL.

WHAT WE HAVE HERE IS A SITUATION THAT MUST BE IMMEDIATELY

ADDRESSED IN A BIPARTISAN FASHION. MANY OF THESE INDIVIDUALS ARE UNABLE TO SPEAK FOR THEMSELVES DUE TO EXTREME PHYSICAL AND EMOTIONAL HARDSHIPS THEY HAVE EXPERIENCED AS A RESULT OF SEVERE DISABILITY. ONE OF THE MANY INDIVIDUALS WHO CAME TO MY OFFICE FOR ASSISTANCE IS A CASE IN POINT. THIS INDIVIDUAL WAS PUT ON THE DISABILITY ROLLS IN 1979 AFTER DEVELOPING A SEVERE HEART CONDITION. HIS DISABILITY WAS SO SEVERE THAT HE WAS FIRST PUT ON THE ROLLS -- WITHOUT APPEAL -- BASED SIMPLY ON THE AVAILABLE MEDICAL EVIDENCE AND NO CONSULTATIVE EXAM WAS ORDERED. WHEN IT CAME TIME FOR THE STATE DISABILITY OFFICE TO REVIEW HIS CASE, WITHOUT SEEKING ADDITIONAL MEDICAL EVIDENCE, HE RECEIVED A NOTICE OF PENDING CESSATION OF BENEFITS. AFTER RECEIVING THIS NOTICE MEMBERS OF MY STAFF CONTACTED THE STATE DISABILITY OFFICE ON HIS BEHALF ONLY TO DISCOVER THAT THIS TERMINATION WAS BASED ON THE REPORT OF AN EXAMINER WHO FELT THE BENEFICIARY WAS TOO SICK TO UNDERGO THE REQUIRED TREADMILL STRESS TEST.

THIS IS THE ONLY AUTHORIZED TEST FOR MEDICALLY VALIDATING THE CONTINUED EXISTANCE OF HIS TYPE OF HEART CONDITION. IT WAS ONLY AFTER CASEWORKERS IN MY OFFICE WERE ABLE TO CONVINCE SUPERVISORY PERSONNEL IN THE STATE DISABILITY OFFICE TO CONTACT THIS BENEFICIARY'S DOCTOR AND TO EXAMINE OTHER AVAILABLE MEDICAL EVIDENCE THAT WE WERE ABLE TO PREVENT THE TERMINATION OF BENEFITS AND THE UNTOLD HARDSHIP THAT WOULD HAVE NEEDLESSLY RESULTED FROM THIS ACTION. UNFORTUNATELY NOT ALL BENEFICARIES CONTACT THEIR SENATOR'S OFFICE NOR ARE WE CAPABLE OF, NOR SHOULD WE BE EXPECTED TO PERSONALLY INTERVENE

ON BEHALF OF DISABILITY BENEFICIARIES. I WAS UNABLE TO ASSIST A LANSING MAN WHO, AFTER BEING ON THE DISABILITY ROLLS FOR 14 YEARS AS A RESULT OF A SEVERE BACK INJURY, STOOD OUTSIDE OF THE LOCAL SOCIAL SECURITY OFFICE AND SHOT HIMSELF SHORTLY AFTER DISCOVERING HIS DISABILITY BENEFITS HAD BEEN TERMINATED.

AT THIS POINT OUR OBJECTIVE SHOULD BE TO IMMEDIATELY ADDRESS THIS TRAGIC SITUATION. WHAT WE HAVE IS A LAW THAT IS BEING ADMINISTERED IN SUCH A FASHION THAT IT HAS PRODUCED UNTOLD AND COMPLETELY UNNECESSARY MISERY FOR HUNDREDS OF THOUSANDS OF AMERICANS. RATHER THAN WAITING FOR CONSTITUENTS TO COME TO OUR OFFICES IN TOTAL DESPERATION SEEKING OUR ASSISTANCE, WE NEED TO ENACT URGENT LEGISLATION TO CORRECT THIS SITUATION. THAT IS THE BEST WAY WE CAN REALLY BE OF ASSISTANCE TO THE SOCIAL SECURITY DISABILITY BENEFICIARIES WHO ARE ASKING FOR OUR HELP.

Senator **Armstrong**. Senator Riegle, we are grateful for a very compelling statement. We appreciate that very much.

Senator Metzenbaum?

STATEMENT OF THE HONORABLE HOWARD M. METZENBAUM, U.S. SENATOR FROM THE STATE OF OHIO

Senator **Metzenbaum**. Mr. Chairman, I am happy to follow my colleague, and I have a magnificently well written statement that I don't intend to read. I will submit it for the record.

But as I sit here, I say to myself, if ever there was a case of government run amok this is it. All over the country people are committing suicide because of these terminations. People are literally driven up against the wall, and we are talking about "We'll have to get around to doing something about the problem."

Now, with no disrespect—and I don't say it with disrespect—the fact is that when an issue arose in the tax conference as to the question of whether capital gains should be held for 6 months or for a year, it was amazing how fast Congress could act on that issue. Overnight the conferees decided to change it, and the next day on the floor of the Senate we had that issue before us and we turned it back again—not with my approval, but we did turn it back again.

I am not criticizing that, then that's fine; but I am saying that here is a problem where people are literally losing their lives, losing everything that means anything to them, and we are talking about the fact that we'll have to get at it. Democrats and Republicans alike are sitting here saying "45 percent of cases considered are terminated; only 50 percent appealed." I believe a substantial proportion of the remaining 50 percent don't appeal because they really don't know what to do.

Let's understand what it is for some of these people. These are people who don't know where to turn, who don't know how to call their Senator's office, who don't know how to call their Congressperson's office. And these are people who need our help.

Now there are times we can argue as to how much food stamps somebody should get or shouldn't get. We can argue about how much AFDC should or shouldn't be available. We can talk about school lunch and school milk programs. Yet, here is a situation where nobody is disputing the facts. I asked the GAO for a report, and they confirmed the problem. And we have a chance to do something about it.

Senator Heinz and I have an amendment to offer to the debt limit bill. Senators Levin and Cohen have an amendment. Their amendment is good, ours goes a little bit further.

But the point that I make is that something should be done—not manana—something ought to be done at the earliest possible time. Now, if we have the resolve to do it, as Senator Riegle has so ably pointed out we can do it for a football game being televised, we sure as the devil can do it if we make up our minds to it. Nobody argues that there are two sides to this issue. Sure, there are some violations that occur. Sure, there are some problems, and some of the people should not be getting these benefits; but we know as a group, every single one of us in the Senate, and probably every person in Congress knows that there is a problem and yesterday was too late.

So I just say to you that my remarks might have been more eloquent, they may have been more persuasive, but I just feel that I would like to leave you with this message.

Senator Dole, you have had a tremendous responsibility. You carried a major burden; you have moved well with respect to the tax bill; you have done some things that I think are very good and some that I have some reservations about; but the fact is, you have moved.

Senator **Dole**. I can still count on you, though.

Senator **Metzenbaum**. All right. [Laughter.]

You have moved. You have the capacity to move on this issue. And I think that you would be performing yeoman's service to show that the Congress can see a challenge and move with rapidity to resolve that challenge.

I for one say whether it is Cohen-Levin or whether it is Heinz-Metzenbaum or whether it is Dole—and that is fine with me; let it be the Dole amendment—let's get this problem resolved. Let's move on it. We don't need to have lengthy hearings; I think we know the problem and I think it's time to act on it. And I would hope that you would provide the leadership that is so necessary to get this matter resolved before the Congress decides to go home. I don't know whether it can be done this week; we may be here next week, or whatever—the faster the better. I think it would be a superb undertaking on your part, and I urge you to do so, and I know that Senator Armstrong is prepared to join you in that endeavor.

Thank you, Mr. Chairman.

[The prepared statement of Senator Metzenbaum follows:]

U. S. Senator Howard M.

METZENBAUM

of Ohio

Committees:
Budget
Energy and Natural Resources
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202-224-2315

for immediate release August 18, 1982

TESTIMONY FOR SENATE FINANCE COMMITTEE FOR SOCIAL SECURITY DISABILITY PROGRAM

Mr. Chairman, I appreciate the opportunity to address this committee today on the subject of the Social Security Disability program. In 1980, Congress mandated a review of the eligibility of Social Security Disability recipients. I believe there are serious problems with the way in which the Social Security Administration is carrying out this mandate. In fact, contrary to the intent of Congress, I believe that thousands of truly disabled persons are having their benefits terminated as a result of this review process.

The numbers speak for themselves: Forty-five percent of all current reviews end up in terminations. Even the GAO report, which has been criticized as unrealistic, only found that, at most, twenty percent of the current beneficiaries might no longer be disabled. What we have then is nothing more than a thinly disguised effort to revamp the disability program and shift the burden of caring for the disabled to the states. But the dismal financial position of most states makes it impossible for them to take on this additional responsibility. As a result, many deserving disability recipients will be lost between the cracks of our assistance programs. And that, Mr. Chairman, simply creates one more ragged hole in our so-called "Safety-Net."

We will probably hear from some witnesses today that the continuing disability investigation program is working largely as intended. They will apologetically explain that any massive review of beneficiaries will unavoidably result in occasional errors. They will insist that the disability horror stories we have heard are simply unfortunate, but isolated incidents. I disagree. What we have here is a case of government run-a-muck.

I first learned of the serious problems in the disability review program last fall. It started as a trickle of complaints, but soon grew into a flood. Today, hundreds of constituents have contacted my office for help in heading off the imminent termination of their disability benefits. Their stories are distressingly familiar.

Each person had been a long time disability recipient who was abruptly informed that they were being dropped from the rolls: Each had letters or documentation from their treating physician that they remained severely disabled and unable to work: Most had lost their benefits after being subject to a cursory, five minute examination by a state-paid physician. Finally, almost all faced a serious financial crisis with the loss of their benefits.

The people who have contacted my office -- and those of other Congressman -- are only the tip of an iceberg. For every person with the sophistication to contact their Congressman, there are countless others with equally compelling cases who don't know where to turn or what to do.

There are several problems with the disability review program which will be addressed by other witnesses. I would like to focus on the most serious of these problems: When Congress passed the 1980 Social Security Disability Amendments mandating reviews at least every three years, did it intend to change the rules in the middle of the game for those receiving benefits?

I believe the answer is clearly "no." The legislative history reveals congressional concern for persons who were working, who had medically recovered, who made fraudulent claims. But Congress was silent on the question of whether those whose condition had not improved should be subject to benefit cut-offs.

A GAO investigation, which I requested last year, found that, "Many of those losing their disability benefits have been on SSA rolls several years, still have what we would all consider to be severe impairments, and have experienced little or no medical improvement." In trying to find an explanation, GAO found that SSA's decision to terminate benefits "is made using a newer, more objective, more stringently interpreted set of evaluation guidelines; and is made in a tougher 'adjudicative climate'."

It seems that over the last several years SSA has significantly narrowed the criteria for disability. Sometimes this is done through regulations and is thus subject to public comment. In other instances, however, these changes are made through informal program guidelines which are not subject to public review. Even more subjective and hidden from the public eye are the case by case reviews by SSA in Baltimore of state agency determinations upholding disability claims. Each time SSA reverses the state, a new, more stringent guideline is created.

Of course, some of the guideline changes do help to achieve more explicit, uniform standards in what is still admittedly a subjective decision-making process. Other changes, however, which narrow the definition of disability rather than clarify it, are much more questionable. A prominent cardiologist with the Cleveland Clinic in Ohio told me that, in his opinion, a person with a heart condition would have to be in the middle of a heart attack to meet SSA's current criteria on cardiac conditions.

But even if one agreed, and I do not, that we need to limit the disability program for future beneficiaries, this is a wholly different question than whether we should be applying these more stringent criteria to current beneficiaries when their cases come up for review. GAO believes the fact that, "Many beneficiaries whose conditions have not improved, or may even have worsened, are being told they are 'no longer disabled', and are terminated from SSA's disability rolls...accounts for much of the adverse publicity given the...review process."

I do not believe that Congress intended this result when it mandated regular reviews. Many courts apparently agree. There are at least five different Federal court decisions at this time which in effect require SSA to show "medical improvement" before benefits can be terminated. SSA, however, will not follow any Federal court decision short of a Supreme Court decision. Its rationale is that Social Security is a national program and should only be governed by a national court decision. But, perhaps aware of its shaky legal position, SSA had studiously avoided a test in the high court. In fact, when an appellate court rules in favor of the recipient, SSA refuses to appeal to the Supreme Court. We thus have a catch 22 situation: SSA will only follow Supreme Court decisions, yet they will not appeal adverse decisions to the Supreme Court!

It is high time that Congress clarify its intent with regard to medical improvement. GAO also agrees that "Congress should state whether cessations are appropriate for those on the disability rolls who have not medically improved." Remember, we are talking about persons who have been labeled by their government as totally disabled, who have been provided with disability insurance payments based on their past contributions to the Social Security Trust Fund, who have been found (again by their government) to be incapable of any substantial gainful employment, who have been out of the workforce for many years living the life of a disabled person, and who are now suddenly informed, despite no change in their condition, that they are no longer disabled and can return to work. This is a cruel and, I believe, unintended, result of the review process.

I will join a number of other Senators in offering an amendment to the public debt ceiling bill to clarify congressional intent on the subject of medical improvement. The situation has reached crisis proportion and requires an immediate, emergency solution. In my own state of Ohio, at least two persons have committed suicide as a direct result of their termination of benefits and many others have died of their disabling condition at the same time that they were told they were no longer disabled. Congress must act immediately to prevent further tragedies from occurring.

Let me say now that I fully support the efforts of Senators Levin and Cohen to slow-down reviews and continue benefits pending an appeal decision. These are both essential changes and I have included them in my own legislation. But in the absence of a "medical improvement" requirement, they will only prolong or delay the inevitable termination of benefits. Therefore, I believe that all three provisions are absolutely necessary to any emergency solution.

Our medical improvement amendment is not intended to prevent SSA from removing persons from the rolls who are not, in fact, disabled, it would allow terminations if the initial decision granting benefits was clearly erroneous or if there was fraud of any kind. It would also allow terminations if, due to advances in medical or rehabilitative technology, a person is now able to work. For instance, a new pacemaker device which allows a person to live a relatively normal life even though their heart condition has not changed might be a reason to terminate benefits. Similarly, advances in dialysis treatment might also now enable some persons to work and justify a termination of benefits.

The supporters of my amendment are not trying to create insurmountable difficulties for the Administration on the disability program. Medical improvement was actually utilized as a criteria by the Administration from 1969 to 1976 and so is not completely unknown to them. I would be most interested in working with the Chairman and other members of this committee to see is we could reach some agreement on the wording of a provision that would be agreeable to all parties.

Finally, we should remember that confidence in the Social Security system is at an all time low. Current beneficiaries have worked and paid into the Disability Insurance Trust Fund. They have earned their right to benefits upon becoming disabled. For the government to go back on the promise it made to these disabled persons will further undermine the already eroding confidence in the system and will lead to an even greater feeling of distrust of government by the American public.

Senator ARMSTRONG. Thank you, Senator Metzenbaum.

Colleagues, please come join us up here. If your schedule permits you to stay for the balance of the afternoon's testimony we would be glad to have you join us.

Senator METZENBAUM. I thank you, Mr. Chairman, but I am due on the floor.

Senator DOLE. I want the record to indicate that they are very effective. The last time they were here was on unemployment compensation. Remember?

Senator METZENBAUM. I remember it very well.

Senator DOLE. Two weeks later we had a $2 billion program. [Laughter.]

Senator HEINZ. Don't give all the credit for that to Senator Metzenbaum. He deserved some of it.

Senator DOLE. No. The last time he was there, but you were up here. Yes, right.

But you make a good point. We certainly will address this as quickly as we can.

Senator GRASSLEY. Mr. Chairman, I have a statement I would like to submit for the record.

Senator ARMSTRONG. We will be very happy to include it in the record.

[The prepared statement of Senator Grassley follows:]

STATEMENT OF SENATOR CHARLES GRASSLEY

Mr. Chairman, I would like to express my thanks to the Chairman and for finding time to hold hearings on a topic of great importance to many of this nation's disabled workers. In view of the flurry of activity during these past few weeks, both Senators are to be commended for their efforts to schedule this review of the continuing disability investigations.

I am sure all of us here today are aware of the increased concern focused on the periodic review of continuing disability. I have received numerous complaints and inquiries from constituents expressing both frustration and anger at the prospect of losing their disability benefits. In my view part of the problem stems from a lack of public understanding of how the review procedure works, and the original intent of the social security disability program.

There is no doubt that the social security disability insurance program, and particularly, the continuing investigation process, is in need of a thorough examination. The growing backlog of cases pending before state agencies and administrative law judges is alarming. Although the intent begind the 1980 Social Security Disability Amendments was valid, it appears we need to evaluate the administrative effects of these changes. During the last Congress, it became increasingly apparent that an overhaul of the disability insurance program was needed to address three concerns: rapid increases in the cost of the program, poor administration of the program, and the problem of work disincentives.

As a result of intensive study, the 1980 amendments were passed, and a subsequent GAO report on the report further indicated the need to tighten up the initial determination process and the review process. It appears that the actual result of these actions has been to mire the state agencies and the appeals network in an unmanageable work schedule, and at the same time raise the anxiety level of those individuals currently receiving disability insurance.

I commend my colleagues here today who have taken the lead in offering legislation to address the problems of the continuing disability investigations. I remain hopeful that among all the various options now pending before the Congress we can effectively analyze the course of events which led to the problem, and agree on the appropriate course of action.

Senator **Mitchell**. I likewise, Mr. Chairman, would like to submit a statement for the record.

Senator **Armstrong**. We would be delighted to have your statement for the record, Senator Mitchell.

[The prepared statement of Senator Mitchell follows:]

OPENING STATEMENT BY SENATOR GEORGE J. MITCHELL

Mr. Chairman:

I am pleased that the Finance Committee is conducting this hearing. I am hopeful that today's hearing will serve as a basis for Congressional action on the issue of disability benefit terminations.

The Social Security Disability Insurance Program is the primary means of replacing lost wages for disabled workers and their families. Roughly 4.4 million people depend on disability benefits. This is not a welfare program; beneficiaries earned the right to this assistance by contributing to the Disability Trust Fund during their working years. Consequently, the Congress and the Administration should be extremely careful in any actions that affect the payment of disability benefits.

This hearing centers on allegations that the Social Security Administration has been unduly harsh in implementing the review of disability cases required by 1980 legislation. This review process, which was scheduled to begin this year but was accelerated by the Reagan Administration, has resulted in record levels of benefit terminations.

Although we need some form of review to see that able-bodied workers are not receiving benefits, there are many signs that current review procedures are faulty.

For example, almost half of all reviews result in benefit terminations, and over 60 percent of those terminations that are appealed are reversed by an Administrative Law Judge. These statistics strongly suggest that beneficiaries whose conditions have not improved are being removed from the disability rolls. This imposes a serious burden on these individuals because they lose their benefits during the appeals process.

There is no shortage of examples to illustrate this point. One of my field representatives recently told me of the following case: An individual from Dennysville, Maine, had been receiving disability benefits for 12 years. He has had one spinal operation and will have another as soon as he is strong enough. He also suffers from angina, chronic emphysema, and a speech impediment. Last fall, his disability benefits were terminated. Since being removed from the disability rolls, this individual has been threatened by foreclosure on his house and repossession of his car, and he faces the prospect of selling all of his personal property. Even if he successfully appeals his termination and receives his lost benefits retroactively, his financial status may be irreversibly harmed.

It is tragic that misguided zeal has led this Administration to encourage wholesale, unwarranted and unfair terminations of people from the disability program. Those who contribute to this program rely on it as their major means of support should they be unable to work, but the erratic decisions of bureaucrats are forcing many people off the disability rolls, despite the fact that they are unable to earn a living. This is not only unfair, it displays astonishing callousness towards people who, through no fault of their own, rely on their government's word when they become disabled.

I look forward to hearing testimony on the adequacy of existing review procedures and on the possible solutions to the problem. I hope that we can act soon, either in the Finance Committee, or, if necessary, by amendment to the debt limit bill.

Senator **ARMSTRONG**. We now call Mr. Paul Simmons, Deputy Commissioner for External Affairs of the Social Security Administration, and those who will be accompanying him, to give us the perspective of this from social security.

Commissioner, we are delighted to have you with us, as always, and we are looking forward to your testimony and to your counsel about where we go from here on this matter.

STATEMENT OF PAUL B. SIMMONS, DEPUTY COMMISSIONER FOR PROGRAMS AND POLICY, SOCIAL SECURITY ADMINISTRATION

Mr. **SIMMONS**. Accompanying me today are Beverly Bedwell, Associate Commissioner for Assessment; Donald Gonya, Health and Human Services' Assistant General Counsel, the Social Security Division; Rhoda Greenberg, Director of the Office of Disability Programs; and Louis B. Hays, Associate Commissioner for Hearings and Appeals.

At the outset, Mr. Chairman, I might say that I think you will find that we agree with more than you might think of what has been said here today in terms of defining some of the problems, but I think we might have some different approaches on how those problems should be resolved.

With your permission, I am submitting for the record a very detailed statement which addresses most of the problems at issue in this hearing and outlines many of the steps we have been taking over the past year to improve the quality and fairness of the continuing disability investigation (CDI) program. That statement is similar to the statements and materials we have submitted at 10 other hearings and markup sessions on the CDI program since last September that have been held here in Washington, plus many field hearings on this subject around the Nation.

In all of these hearings we have tried repeatedly to establish the facts at issue here. I think I need not take this committee's time to repeat every detail of those facts.

But I would like to take a few moments today to respond to some of the criticisms that have been leveled against the Social Security

Administration and the 54 State disability determination agencies that have been struggling to carry out the mandate of the Congress on CDI's. And I would like to use part of this time to outline some of the more major steps that we have been taking in close concert with the States to implement some constructive changes in the CDI program.

These reforms, which Secretary Schweiker and Commissioner Svahn have made a top priority of this agency, will, I believe, go a long way toward solving many of the problems and resolving many of the issues that have led to this hearing and many others being held here in Washington. Indeed, we believe we are moving about as far as we can go toward those ends, short of substantive legislation, to correct some of the anomalies in present law and practice which have helped make this program far more complex and controversial than any other administered by this agency.

As you know, Secretary Schweiker and Commissioner Svahn have been strongly supportive of major elements of a Ways and Means Social Security Subcommittee bill, which has not yet been acted on by the full House. I might add that we are quite proud to have been able to work with Chairman Pickle and Congressman Archer and their colleagues on that committee, and then with the full committee. We think many elements of that bill would be extremely helpful to us. We had hoped, in fact, that that bill—which is H.R. 6181, with provisions that are paralleled in several bills before this committee as well—that would be the law of the land by now.

There are certain provisions of that bill, along with the steps that we are taking administratively, that will be critical to the integrity of the program and the fairness of the CDI process, and it is these two issues, fairness to recipients and program integrity, which we believe must be the basis of any changes made in this program.

Many of the reforms that I am outlining for you today carry out, to the extent that we can within the constraints of the law we have to work with, the spirit and intent embodied in the House bill and in some provisions of bills pending before this committee.

For example, in anticipation of congressional action on an acceptable version of the House bill, we will move in the coming months to develop plans for the kind of face-to-face evidentiary hearing envisioned for the reconsideration level of appeal in that bill. Several Senators remarked earlier today, and they are quite right, that one of the anomalies in the system is that most applicants and beneficiaries don't come face-to-face with any decisionmaker until far down the line, which may be 6 to 9 months from the time when the process starts.

We cannot, as that bill would mandate, stretch the deadline for appeal for reconsideration to 6 months and pay benefits to recipients for up to that length of time, but we do support those provisions. We just cannot implement them without clear congressional action.

But we can work with the States to reform other aspects of the reconsideration process and convert it from what it is now—a largely paper-oriented review—into a people-focused review that should go a long way toward insuring that first-level appeals are full, fair, and fast, and based on all medical evidence available.

In any of the actions we are taking, I must note, we do not intend to supplant but rather to supplement the good work of the State disability agencies. Their partnership with us is one of the most unique and productive among Federal-State programs. Our reforms are designed only to make that partnership more so. Indeed, much of our administrative reform effort is based on the sound advice and proven expertise of several State agency administrators who have consented to serve as advisers to us in this effort. The States, like the Social Security Administration, want this program to be as fair to the recipient and as responsible to the taxpayer as we can possibly make it.

To help relieve the workloads on those States with unusually large backlogs of cases to be reviewed, we are exercising this month and next a selective moratorium on forwarding new cases to those States. Over these 2 months we will be holding up more than 33,000 cases which otherwise would have been sent to the States for action. And, with respect to future State agency and administrative law judge backlogs and workloads, based on our findings in the first year of the CDI program, we have broadened somewhat our definitions of the "permanently disabled" who need not be subject to the once-every-3-year CDI process mandated under the law. As a result, we expect to exempt up to an additional 165,000 beneficiaries from the CDI process during the next fiscal year, which will mean reducing the total from about 800,000 which was originally projected to about 640,000. That will be a major reduction in workloads and one which we think the States and the ALJ system will be able to handle given other movements in their workloads.

Other elements of our reform program are also detailed in my statement for the record. To summarize them briefly: First, we have doubled our number of reviews of State agency actions to deny or cease benefits to individuals. Under present law and practice we have been required to review only favorable State decisions, an anomaly that can obviously skew a close-call decision. The House bill would mandate that a mix of favorable and unfavorable decisions be reviewed, something we are already doing to insure that the decisionmaking process and the CDI process are as neutral as humanly possible.

Second, since March we have stopped the past practice of the agency of trying to recoup payments from individuals removed from the rolls, dating all the way back to the date of probable cessation of the disability. This is also a provision in the pending House bill which we support but which we don't think is necessary. Under this policy we stop payments at the time the person is notified of the termination except in cases where there has been outright fraud or other good reason to try to go back and recover past payments, that or to prosecute.

Third, since May of this year we have mandated that States review all medical evidence available dating back at least a year, a directive which we think will help insure that every State is looking at every piece of evidence that might be pertinent to a case.

Fourth, we have added more than 140 administrative law judges to what is already perhaps the largest single adjudicative system in the world, bringing their total number to more than 800 and providing them with significantly more support staff to help reduce the backlog of cases that has been a chronic problem in past years.

Indeed, I should note here that our sense of management priority is reflected in the fact that we devote more than half of our entire agency's administrative budget to the disability program, even though it serves only about one-sixth of all of our beneficiary population.

Fifth, finally, we are moving to insure that all levels of the appeals process, including the administrative law judge system and our appeals council, are adjudicating cases on the same basis of law and regulation. Thus, we are moving administratively to address a chronic problem of inconsistency in decisions, which is also addressed in the House bill by a mandate for us to do essentially what we are already doing ourselves.

We support the House bill provisions in this sensitive area because they would enable us to go further than we now can to insure that each level of appeal is as fair and conclusive as possible.

In conclusion, Mr. Chairman, I would like to offer quite another perspective on this program than you may be hearing from some people this afternoon. I think we do sometimes lose perspective on how this program came about and why it came about.

The periodic review process is part and parcel of our ongoing mission to insure that disability benefits are paid only to those individuals who meet the criteria established in the law. In the vast majority of cases, as my statement for the record points out, the reason people are being taken off the rolls is not because of deficiencies in the process but because they are not disabled under the terms of the law. Many of them were on the rolls erroneously to begin with, and many of them recovered after they came on the rolls. We are now paying the price, because the necessary emphasis was not put on quality in original decisions and there was not a strong ongoing program for reviewing the existing disability rolls.

Once we complete our review of the existing disability rolls and we maintain high quality in the initial determination and appeal process, the proportion of terminated beneficiaries should decline drastically.

We fully agree that we need some constructive, creative action on this program, both administratively and legislatively. Why we need such action is clear in the light of a thumbnail history of this program:

The Congress enacted this program 26 years ago—a quarter century. It was an extremely strict program then; it is extremely strict now. Over the quarter century the disability program has been in place, the Congress, successive administrations of both parties, and any number of court decisions have acted to liberalize or restrict the eligibility criteria or contract or expand benefits as the temper of the times dictated.

For a long time, for example it was possible for a worker to get more in tax-free disability benefits than he could get on the job—which is a strong incentive to get on and stay on the program.

For a long time it was possible for convicted felons to collect disability benefits while sitting in prison for gross crimes. Congress did finally act to stop that, but only after 24 years.

For a long time most workers who made it into the program could rest assured that they were on a lifetime tax-free adjusted-for-inflation retirement annuity. They would never be asked to prove continuing eligibility.

For a long time the disability insurance program offered a long-term tempting alternative to taking an early retirement at 62 and accepting the 20-percent loss of benefits. And indeed, today more than half of all DI beneficiaries are over the age of 55.

For a long time the rules didn't change all that much, despite startling advances in medical therapy and technology that made wholesale changes in our notions of what disability is and how people can cope with it. Indeed, there are people we see on the streets going to work every day who are suffering from handicaps or disabilities that are far more serious than those of many people who are now on the rolls.

For an unprecedented time in the mid-1970's the Federal and State agencies responsible for administering the disability program had to grapple with the sudden creation of the supplemental security income program, which added millions of new disability cases to their workloads in a matter of months with precious little leadtime, and which had obvious effects on the quality of decisions made in the cases of those who flooded into the program. Many of those decisions are now at issue in the CDI process.

All of these forces gathered over time to make the disability insurance program perhaps the single fastest growing benefit program and perhaps the single most abused. Between 1970 and 1980 the disability caseload grew 75 percent; its costs in 1980 were 500 percent of the 1970 level. And that was at a time when the national rates of long-term sickness and disabling injuries had not materially changed among the general population. And the cost of living during that time went up only 30 percent as fast as the cost of this program. Thus, there are good and obvious reasons why the Carter administration and the Congress and the Congress own audit agency supported the amendments of 1980. And for the same reasons this administration is pursuing the clear intent of the Congress and the American taxpayer: At a time when the social security system has serious problems in terms of both dollars and public confidence, we cannot tolerate any doubt about how we are spending $18 billion in trust fund moneys this year—which is exactly the issue we are talking about at this hearing today.

We can argue about whether it is possible within the 3 short years Congress has given us to right every wrong, to clear up every excess, and to eliminate every abuse that has evolved in this program in the past quarter century; but, no, we cannot argue that there is no reason to act. We have no choice but to act. Our quality assurance surveys show that as many as 1 in 4 of those on the rolls do not meet the test of the law.

Mistakes are being made in the process of trying to clean up the rolls. I will apologize for the mistakes, but I can't make excuses for them. If there are errors and failures in this program, they are not this administration's, they are errors and failures of the United States Government over a long period of time.

And that is precisely why we are making administrative changes and why we are supporting legislative improvements that will rectify those elements of the law and its administration that must be changed to insure that this program is fair to one and all—to the beneficiary and to the taxpayer who is asked to support that beneficiary.

I thank you for your time, and I would be glad to answer any questions.

[The prepared statement of Paul B. Simmons follows:]

STATEMENT
OF
PAUL B. SIMMONS
DEPUTY COMMISSIONER OF SOCIAL SECURITY

OVERSIGHT HEARING ON SOCIAL SECURITY
DISABILITY INSURANCE PROGRAM
COMMITTEE ON FINANCE
U.S. SENATE

WEDNESDAY, AUGUST 18, 1982

MR. CHAIRMAN AND MEMBERS OF THE COMMITTEE

I APPRECIATE THE OPPORTUNITY TO APPEAR BEFORE YOUR COMMITTEE. I AM ACCOMPANIED THIS AFTERNOON BY MS. BEVERLY A. BEDWELL, ASSOCIATE COMMISSIONER FOR ASSESSMENT, MR. DONALD A. GONYA, ASSISTANT GENERAL COUNSEL, HHS, SOCIAL SECURITY DIVISION, MS. RHODA GREENBERG, DIRECTOR OF THE OFFICE OF DISABILITY PROGRAMS, AND MR. LOUIS B. HAYS, ASSOCIATE COMMISSIONER FOR HEARINGS AND APPEALS.

THE FOLLOWING STATEMENT DETAILS THE HISTORY, CURRENT STATUS, AND RECENT IMPROVEMENTS IN CONTINUING DISABILITY INVESTIGATIONS. MY ORAL STATEMENT SUMMARIZES THIS PRESENTATION AND DESCRIBES SOME NEW INITIATIVES WE ARE ABOUT TO EMBARK ON.

I WOULD LIKE TO DISCUSS WITH YOU TODAY THE PERIODIC REVIEW THAT WE HAVE BEEN CONDUCTING SINCE MARCH 1981 AND ITS EFFECTS ON BENEFICIARIES, THE QUALITY OF DECISIONMAKING, AND ON PROCESSING TIMES. I ALSO WANT TO ENUMERATE THE MANY STEPS WE HAVE BEEN TAKING TO REFINE THE PERIODIC REVIEW PROCESS AS WE GO ALONG, AS WELL AS THE IMPROVEMENTS WE ARE MAKING IN THE OVERALL DISABILITY DECISIONMAKING PROCESS.

INTRODUCTION

FROM THE INCEPTION OF THE DISABILITY BENEFIT PROGRAM IN 1956, THE DEFINITION OF DISABILITY HAS ALWAYS BEEN VERY STRICT, AND CAN ONLY BE MET BY THE VERY SEVERELY DISABLED. PARTIAL DISABILITY, WHICH IS RECOGNIZED IN MANY OTHER BENEFIT PROGRAMS, IS NOT SUFFICIENT FOR SOCIAL SECURITY DISABILITY BENEFITS.

THE SOCIAL SECURITY ACT PROVIDES THAT A CLAIMANT'S IMPAIRMENT(S) MUST BE SO SEVERE THAT HE IS NOT ONLY UNABLE TO DO HIS PREVIOUS WORK BUT CANNOT, TAKING INTO CONSIDERATION HIS AGE, EDUCATION, AND WORK EXPERIENCE, ENGAGE IN ANY OTHER KIND OF SUBSTANTIAL GAINFUL WORK WHICH EXISTS IN THE NATIONAL ECONOMY. SO LONG AS THIS WORK EXISTS IN THE NATIONAL ECONOMY, IT DOES NOT MATTER WHETHER SUCH WORK EXISTS IN THE IMMEDIATE AREA IN WHICH HE LIVES, OR WHETHER A SPECIFIC JOB VACANCY EXISTS FOR HIM, OR WHETHER HE WOULD BE HIRED IF HE APPLIED FOR WORK. THE DISABILITY MUST BE EXPECTED TO RESULT IN DEATH OR MUST HAVE LASTED, OR BE EXPECTED TO LAST, FOR A CONTINUOUS PERIOD OF 12 MONTHS OR MORE. THIS IS THE STATUTORY LANGUAGE, NOT SSA'S INTERPRETATION OF THE STATUTE. THE SAME DEFINITION OF DISABILITY APPLIES NOT ONLY TO THOSE INITIALLY FILING FOR BENEFITS, BUT ALSO IN DETERMINING WHETHER BENEFICIARIES SHOULD REMAIN ON THE ROLLS.

THE ORIGINAL DEFINITION OF DISABILITY FOR SOCIAL SECURITY BENEFITS WAS EVEN MORE SEVERE THAN THE PRESENT ONE; IT REQUIRED THAT THE IMPAIRMENT BE EXPECTED TO RESULT IN DEATH OR TO BE OF LONG-CONTINUED AND INDEFINITE DURATION. THE PRESENT DEFINITION WAS ADOPTED IN 1965, AT WHICH TIME THE CONGRESS INDICATED THAT IT EXPECTED SSA TO REVIEW THE CONDITION OF BENEFICIARIES periodically to assure prompt termination of benefits when a beneficiary ceased to be disabled.

However, aside from statutory changes in the definition, advances in medical science have resulted in de facto changes. Due to the availability of kidney transplants, bypass surgery, and new medications for mental illnesses, for example, certain medical conditions which were permanently disabling in the past may not be disabling today. Thus, medical advances may require changes in CDI procedures since people considered permanently disabled when they came on the rolls may no longer be disabled. In addition to liberalizing the definition, Congress made other eligibility requirements for disability less restrictive; for example, the insured status requirements were liberalized twice.

A number of occurrences in the 1970's raised concerns about the program. While the program grew relatively slowly during the 1960's, it began to grow rapidly during the early 1970's. In FY 1969, SSA received 700,000 claims for disability benefits. By 1974, the number of disability claims per year had grown to 1.2 million. Part of this growth can be attributed to adverse economic periods because high unemployment encourages some workers with significant health problems to file for disability benefits.

In addition, over 500,000 claims under the Black Lung program, which started in 1970, had been filed over a relatively

SHORT PERIOD OF TIME, AND SSI DISABILITY CLAIMS ADDED ALMOST ANOTHER MILLION CLAIMS A YEAR AFTER THAT PROGRAM'S IMPLEMENTATION IN JANUARY 1974. THE ADVENT OF THESE NEW PROGRAMS REQUIRING DISABILITY DECISIONS PUT A STRAIN ON THE DISABILITY DETERMINATION PROCESS. THE RESULT WAS TREMENDOUS PRESSURE TO PROCESS CLAIMS QUICKLY AND REDUCE BACKLOGS. AT THE SAME TIME, THERE WAS AN EFFORT TO HOLD DOWN PROCESSING COSTS, PRODUCING A CONFLICT BETWEEN QUALITY AND QUANTITY.

BY 1975 THESE FACTORS RESULTED IN THE HIGHEST DISABILITY INCIDENCE RATE IN THE HISTORY OF THE DISABILITY INSURANCE PROGRAM; THERE WERE 7.1 DISABLED WORKER BENEFICIARIES PER THOUSAND WORKERS. IN CONTRAST, THE DISABILITY INCIDENCE RATE WAS 3.5 IN 1981. WHILE DISABILITY INCIDENCE HAS FLUCTUATED WIDELY OVER THE YEARS, THE RATES OF SICKNESS AND INJURY HAVE NOT CHANGED APPRECIABLY IN THE GENERAL ECONOMY.

CURRENTLY, THE SOCIAL SECURITY TRUST FUNDS ARE RUNNING A DEFICIT THAT MOUNTS BY $17,000 PER MINUTE, AND 44 PERCENT OF THAT TOTAL CAN BE ATTRIBUTED TO THE PAYMENT OF DI BENEFITS TO PEOPLE WHO ARE NOT DISABLED.

AS INCIDENCE RATES AND COSTS INCREASED, CONCERNS BEGAN TO BE EXPRESSED ABOUT THE QUALITY OF ADMINISTRATION OF THE DISABILITY PROGRAM. IN 1979, BOTH THE CARTER ADMINISTRATION AND THE CONGRESS MADE RECOMMENDATIONS FOR IMPROVING THE ADMINISTRATION OF THE PROGRAM AND CUTTING COSTS, CULMINATING IN the enactment of P.L. 96-265, the "Social Security Disability Amendments of 1980." These amendments contained provisions aimed at (1) restraining the costs of the program (e.g., a cap on family benefits and restrictions on dropout years); (2) improving work incentives; and (3) improving program administration (e.g., closing the record after the hearing, own-motion review of ALJ decisions, and preeffectuation review of initial decisions). Among the latter was the provision for periodic review of the Social Security disability rolls.

HISTORY OF THE CDI PROCESS

SSA has always reviewed disability cases to assure that beneficiaries' disabilities are continuing. However, before the periodic review process was enacted in 1980, only certain kinds of disability cases were reviewed: (1) those in which the disabled beneficiary's medical condition was expected to improve; (2) those in which the beneficiary's earnings record indicated work activity; and (3) those in which a beneficiary voluntarily reported work activity or medical improvement.

In recent years, SSA began to question whether this CDI process was adequate. It was clearly not designed to identify cases in which the initial determination of disability was incorrect, or those in which, because of the statutory changes and medical advances I mentioned earlier, the impairment might no longer be considered disabling. Also, only a small percentage of those cases in which improvement could be expected were being reviewed.

Congress was also concerned about the effectiveness of the CDI process, and, as I mentioned, in 1980 they enacted the periodic review requirements. This provision requires SSA to review all nonpermanent disabilities at least once every 3 years and permanent disabilities at such times as the Secretary considers appropriate. The legislation required that SSA begin the periodic review in January 1982.

As it turns out, the concerns which led to enactment of P.L. 96-265 were well founded. In fact, the situation was even worse than we had imagined.

A 1981 GAO report, entitled "More Diligent Followup Needed to Weed Out Ineligible SSA Disability Beneficiaries," indicated that as many as 584,000 beneficiaries, about 18 percent of the disability rolls, did not meet the eligibility criteria.

Newer data are even more alarming:

-- A special SSA review of 25,000 cases (representative of 50 percent of the disability beneficiary population) indicated that 33 percent were not disabled.

-- Another special SSA review of a statistically valid random sample of 2,800 cases (representative of the entire disability rolls) indicated that 30 percent were not entitled to benefits.

-- Based on this 2,800 case study, SSA was able to determine that as much as $4 billion is paid out annually to people who are not disabled.

ACCELERATION OF PERIODIC REVIEW

In light of findings in GAO and SSA studies that huge sums of benefits were being paid incorrectly, the Administration decided not to wait until 1982 to accelerate the periodic review process mandated by the Congress. The decision to go to accelerated review was also prudent administratively. Before we made this decision to accelerate the review, we had projected about 580,000 periodic review CDI's for the 9 months beginning January 1, 1982, in addition to regularly scheduled CDI's. Instead, by starting in March 1981, we had 18 months in which to spread the first year periodic review workload, thus minimizing its impact on the State agencies.

The Administration's decision to accelerate the review of the disability rolls was fully supported with appropriate staffing and other necessary resources. In fiscal years 1981 and 1982, we significantly increased staffing and funding for

THE STATE AGENCIES WHICH MAKE DISABILITY DETERMINATIONS FOR SSA IN INITIAL AND RECONSIDERATION CASES, INCLUDING CDI'S. TOTAL STATE AGENCY STAFF INCREASED 33 PERCENT BETWEEN FY 1980 AND FY 1982, WHILE FUNDING INCREASED 64 PERCENT FOR THE SAME PERIOD. STAFF OF THE OFFICE OF HEARINGS AND APPEALS, WHICH HAS RESPONSIBILITY FOR ADJUDICATING HEARINGS, ALSO INCREASED 12 PERCENT AND FUNDING LEVELS FOR OHA ROSE 30 PERCENT BETWEEN FY 1980 AND FY 1982.

I THINK IT IS IMPORTANT TO NOTE AT THIS POINT THAT, THIS YEAR, WE ESTIMATE SPENDING OVER ONE-HALF OF OUR ADMINISTRATIVE BUDGET TO RUN THE SOCIAL SECURITY AND SSI DISABILITY PROGRAMS, WHICH ACCOUNT FOR ONLY 17 PERCENT OF THE COMPARABLE BENEFIT POPULATION.

OVERVIEW OF THE CDI PROCESS

BEFORE I DISCUSS THE IMPACT OF THE CURRENT CDI PROCESS, I WANT TO GIVE YOU AN OVERVIEW OF HOW THE PROCESS WORKS. AS THE FIRST STEP, SSA CHOOSES THE CASES FOR REVIEW BASED UPON PROFILES, DEVELOPED THROUGH SPECIAL STUDIES, OF THE NON-MEDICAL CHARACTERISTICS OF CASES IN WHICH BENEFICIARIES ARE MOST LIKELY TO BE INELIGIBLE. THESE CASES ARE THEN SCREENED TO ELIMINATE ANY INVOLVING PERMANENT DISABILITIES FROM THE REVIEW PROCESS.

SSA THEN TRANSFERS THE CASE FOLDERS TO THE STATE AGENCIES, WHICH NOTIFY BENEFICIARIES THAT A REVIEW HAS BEEN UNDERTAKEN.

THE BENEFICIARY IS ASKED TO GIVE THE STATE AGENCY INFORMATION ABOUT THE CURRENT STATUS OF HIS CONDITION AND ABOUT WHEN AND WHERE HE HAS RECENTLY RECEIVED MEDICAL TREATMENT. THIS INFORMATION IS USED TO OBTAIN ALL CURRENT MEDICAL EVIDENCE THAT IS AVAILABLE.

IF THE CURRENT MEDICAL EVIDENCE IS NOT DETAILED ENOUGH, OR IF THE BENEFICIARY HAS HAD NO RECENT MEDICAL TREATMENT, THE STATE AGENCY ARRANGES A SPECIAL EXAMINATION OF THE PERSON'S PRESENT CONDITION, CALLED A CONSULTATIVE EXAMINATION, AT GOVERNMENT EXPENSE.

THROUGH THE FIRST 13 MONTHS OF THE ACCELERATED REVIEW, ABOUT 54 PERCENT OF THE CONTINUING DISABILITY CASES REVIEWED BY THE STATE AGENCIES HAD CONSULTATIVE EXAMINATIONS PERFORMED. THIS IS ALMOST 15 PERCENT HIGHER THAN THE PERCENTAGE OF INITIAL AND CDI CASES IN WHICH CONSULTATIVE EXAMINATIONS WERE PERFORMED IN THE PAST. I SHOULD NOTE THAT, IN FISCAL YEARS 1983 AND 1984, WE ARE BUDGETING FOR A 50-PERCENT CONSULTATIVE EXAMINATION RATE IN CONTINUING DISABILITY CASES. I MIGHT MENTION THAT WE HAVE TAKEN SEVERAL SIGNIFICANT STEPS TO IMPROVE OUR MONITORING OF STATE AGENCY PURCHASES OF MEDICAL EVIDENCE. I AM SUBMITTING THE ATTACHED DESCRIPTION OF THOSE STEPS FOR THE RECORD.

I WANT TO EMPHASIZE THAT IN EVERY CDI CASE WE OBTAIN EVIDENCE OF THE BENEFICIARY'S CURRENT MEDICAL CONDITION--EITHER from his physician or through a consultative medical examination--before making a decision.

The State agency then evaluates the medical evidence and determines whether the beneficiary continues to be disabled within the meaning of the law. I want to stress that no "termination quota" has been imposed for the CDI's. The States must follow the same policies and procedures for periodic review that they followed for CDI's before periodic review. States are instructed to develop and adjudicate each case on its own merit, according to the policies and procedures in the Federal regulations and SSA's operating policies and procedures.

Those individuals who are found to be still disabled are informed by letter that their eligibility has been reviewed and their benefits will continue. Those who are found to be no longer disabled are given advance notice of this finding and are given 10 days in which to advise the State agency that they disagree with it and plan to submit additional evidence. The beneficiary has a reasonable amount of time after that to present the additional evidence.

If, after evaluating the additional evidence, the State agency still finds that the beneficiary does not meet the definition of disability in the law, the beneficiary is notified of this finding and is informed that he may appeal the decision by requesting a reconsideration within 60 days of the notice of termination. I might note that under the law the beneficiary is paid benefits for the month that the period of disability is terminated and for 2 additional months.

When a reconsideration is requested, the State agency secures updated medical evidence from the beneficiary's treating sources and requests a consultative examination if one is needed. The reconsideration determination is made by different State agency personnel than made the initial decision. The beneficiary is then notified of the reconsideration decision and his appeal rights. The beneficiary has 60 days after notification of the reconsideration determination to request a hearing before an Administrative Law Judge, at which point he may appear in person to present evidence and give testimony. If dissatisfied with the ALJ's decision, the beneficiary may appeal the ALJ's decision to SSA's Appeals Council, and ultimately to a Federal court.

I might mention that in some respects the SSI appeals process for CDI cases is different from the Social Security process. For example, there is no reconsideration step in the SSI appeals process.

IMPACT OF CONTINUING DISABILITY REVIEWS

Next I want to discuss the CDI process in terms of: (1) the impact on claimants and beneficiaries, (2) the quality of the review process; and (3) the impact on hearings.

IMPACT ON CLAIMANTS AND BENEFICIARIES

SINCE MARCH 1981 WHEN WE BEGAN THE ACCELERATED REVIEW, OVER 400,000 DISABILITY BENEFICIARIES HAVE HAD THEIR ELIGIBILITY REVIEWED (EITHER BECAUSE OF PERIODIC REVIEW OR BECAUSE THEIR CASES WERE SCHEDULED FOR REVIEW BECAUSE THEIR MEDICAL CONDITIONS WERE EXPECTED TO IMPROVE), AND MORE THAN 212,000 HAVE HAD THEIR BENEFITS TERMINATED AT THE INITIAL DECISIONMAKING LEVEL. THERE HAVE BEEN PERIODS WHEN THE PROCESS HAS AFFECTED NEW CLAIMANTS FOR DISABILITY BENEFITS TOO; OVERALL STATE AGENCY PROCESSING TIMES ROSE FROM 44.0 DAYS IN THE FIRST QUARTER OF 1981 TO A HIGH OF 50.3 DAYS IN THE FIRST QUARTER OF 1982, BUT DECREASED TO 45.0 DAYS FOR THE QUARTER ENDING JUNE 1982. I MUST EMPHASIZE THOUGH THAT WHILE PROCESSING TIMES HAVE INCREASED AT TIMES, THE ACCURACY RATE FOR INITIAL STATE AGENCY DECISIONS HAS UNDERGONE LITTLE CHANGE. ALSO, SOME OF THE INCREASE IN PROCESSING TIMES IS DUE TO FACTORS SUCH AS THE PREPARATION OF PERSONALIZED DENIAL NOTICES AS REQUIRED UNDER THE 1980 AMENDMENTS AND THE REQUIREMENT FOR A PHYSICIAN'S SIGNATURE ON MEDICAL EVIDENCE.

WE BELIEVE THAT SOME OF THE ADVERSE REACTION TO THE CDI PROCESS STEMS FROM MISUNDERSTANDING AMONG THE GENERAL PUBLIC OF THE FACT THAT THE PERIODIC REVIEW PROCESS IS MANDATED BY LAW, AND THAT THE DEFINITION OF DISABILITY FOR SOCIAL SECURITY BENEFITS IS VERY STRICT. THE ADVERSE REACTION OF SOME DISABILITY BENEFICIARIES TO PERIODIC REVIEW IS ALSO BASED ON MISUNDERSTANDING. MOST BENEFICIARIES NEVER EXPECTED TO HAVE

THEIR CASES REVIEWED AGAIN; IN THEIR OWN MINDS THEY HAVE "RETIRED" ON DISABILITY. AS A RESULT, TERMINATED BENEFICIARIES HAVE TO MAKE TREMENDOUS PSYCHOLOGICAL ADJUSTMENTS. AND OF COURSE CURRENT ECONOMIC CONDITIONS--UNEMPLOYMENT IS HIGH AND JOBS ARE SCARCE--ADD TO THEIR ANXIETIES.

IT HAS BEEN SUGGESTED THAT THE CDI PROCESS HAS BEEN UNFAIRLY FOCUSED ON BENEFICIARIES WITH MENTAL IMPAIRMENTS. LET ME ASSURE THE COMMITTEE THAT THIS IS NOT THE CASE. TWO FACTORS MAY ACCOUNT FOR WHAT SEEMS TO BE A LARGE NUMBER OF MENTAL IMPAIRMENT CASES THAT ARE COMING UP FOR PERIODIC REVIEW AT THIS TIME.

FIRST, WE ESTIMATE THAT THERE IS A GREATER PERCENTAGE OF MENTAL IMPAIRMENTS AMONG BENEFICIARIES WHO HAVE BEEN ON THE ROLLS FOR SOME TIME THAN AMONG THOSE NEWLY ALLOWED. THIS IS PRIMARILY DUE TO THE FACT THAT BENEFICIARIES WITH MENTAL IMPAIRMENTS TEND TO BE YOUNGER THAN THE AVERAGE NEW DISABILITY BENEFICIARY AND STAY ON THE ROLLS LONGER THAN THOSE WITH OTHER IMPAIRMENTS. ALSO, BECAUSE MEDICAL REEXAMINATION DIARIES WERE NOT GENERALLY ESTABLISHED FOR SUCH BENEFICIARIES WITH MENTAL IMPAIRMENTS, FEW OF THEM HAVE BEEN REMOVED FROM THE ROLLS IN THE PAST AS THE RESULT OF A CDI REVIEW.

SECOND, IMPAIRMENTS SUCH AS NEUROSES AND PSYCHOSES CANNOT BE PRESUMED TO BE PERMANENTLY DISABLING. THUS, FEW CASES INVOLVING MENTAL IMPAIRMENTS ARE SCREENED OUT AS PERMANENT

DISABILITIES BY THE SELECTION PROCESS WE USE TO IDENTIFY NON-PERMANENT DISABILITIES FOR REVIEW. THIS RESULTS IN RELEASING MORE MENTAL IMPAIRMENT CASES FOR CDI REVIEWS THAN MIGHT OTHERWISE BE EXPECTED IF STRAIGHT PERCENTAGES WERE APPLIED TO EACH BODY SYSTEM.

SSA FOR MANY YEARS HAS HAD SPECIAL PROCEDURES FOR ASSISTING CLAIMANTS WHO NEED HELP IN DEVELOPING EVIDENCE TO SUPPORT THEIR CLAIMS. FOR EXAMPLE, WE TELL BOTH OUR SOCIAL SECURITY CLAIMS PERSONNEL AND STATE DDS ADJUDICATORS THAT WHEN A CLAIMANT HAS A MENTAL IMPAIRMENT OR THERE IS OTHER EVIDENCE INDICATING THAT HE/SHE IS UNABLE TO UNDERSTAND A WRITTEN NOTICE, IT MAY BE NECESSARY TO WORK WITH CLOSE RELATIVES OR OTHER INTERESTED PARTIES IN GATHERING EVIDENCE TO ADJUDICATE THE CLAIM.

QUALITY OF THE REVIEW PROCESS

TO MONITOR THE PERFORMANCE OF STATE AGENCIES IN MAKING CONTINUING DISABILITY DECISIONS, SSA PERFORMS A QUALITY ASSURANCE (QA) REVIEW. THE REVIEW INVOLVES A RANDOM SAMPLE OF RECENT STATE AGENCY DDS DECISIONS AND IS DESIGNED TO DETERMINE THE EXTENT TO WHICH STATE AGENCY DECISIONS PROPERLY REFLECT THE ELIGIBILITY CRITERIA IN THE LAW AND REGULATIONS. UNDER THIS REVIEW, 97.5 PERCENT OF CONTINUING DISABILITY DETERMINATIONS IN THE 5-MONTH PERIOD ENDING MARCH 1982 WERE FOUND TO BE CORRECT. THE FIGURES WERE 97.4 PERCENT FOR CONTINUANCES AND 97.[illegible] PERCENT FOR TERMINATIONS. THIS SHOWS THAT THE ACCURACY OF OUR CDI

REVIEWS IS VERY GOOD. OF COURSE THERE IS ALWAYS ROOM FOR IMPROVEMENT AND, AS I WILL DISCUSS LATER, WE ARE UNDERTAKING A NUMBER OF INITIATIVES AIMED AT MAKING IMPROVEMENTS.

IMPACT ON HEARINGS

OUR HEARINGS WORKLOAD HAS BEEN INCREASING AND AS A RESULT PROCESSING TIMES HAVE INCREASED. TOTAL HEARINGS REQUESTS HAVE INCREASED FROM 135,000 IN THE FIRST 9 MONTHS OF FY 1981 TO 154,000 IN THE SAME PERIOD IN FY 1982. IN MARCH 1982, WE RECEIVED 31,000 REQUESTS, WHICH IS BY FAR THE MOST WE HAVE EVER RECEIVED IN A SINGLE MONTH. THERE HAS ALSO BEEN AN INCREASE IN PROCESSING TIME FOR HEARINGS, FROM 154 DAYS IN FY 1981 TO 172 DAYS IN THE FIRST 9 MONTHS OF FY 1982.

FOR BUDGET PURPOSES, WE ARE PROJECTING 328,000 REQUESTS FOR HEARINGS IN FY 1982 AND MORE THAN 400,000 IN FY 1983, COMPARED TO 281,000 IN FY 1981. THIS PROJECTED INCREASE IN HEARINGS REQUESTS INCLUDES EXPECTED INCREASES DUE TO CDI HEARINGS REQUESTS. HOWEVER, APPEALS ARE EXPECTED TO LEVEL OFF TO SOME EXTENT ONCE WE HAVE REVIEWED THE EXISTING DISABILITY ROLLS.

LOWER LEVEL DECISIONS THAT ARE APPEALED ARE NOW BEING REVERSED BY ALJ'S IN APPROXIMATELY 50 PERCENT OF NON-CDI CASES AND 50 PERCENT OF CDI CASES. THIS OF COURSE RAISES THE QUESTION, "IF OUR QUALITY APPRAISAL SHOWS A 97.5 ACCURACY RATE

FOR INITIAL STATE AGENCY CDI DECISIONS, WHY IS THE ALLOWANCE RATE AT THE HEARINGS LEVEL SO HIGH?"

THERE ARE A NUMBER OF FACTORS WHICH CAN RESULT IN ALLOWANCES AT THE HEARINGS LEVEL, INCLUDING THE SUBJECTIVITY OF THE DECISIONMAKING PROCESS, THE FACE-TO-FACE CONTACT WITH THE BENEFICIARY THAT FIRST OCCURS AT THE HEARING LEVEL, THE POSSIBILITY OF PROGRESSIVE WORSENING OF THE CLAIMANT'S MEDICAL CONDITION DURING THE COURSE OF THE VARIOUS REVIEWS OF THE CLAIM, AND THE FACT THAT ADDITIONAL EVIDENCE MAY BECOME AVAILABLE AT THE HEARING LEVEL FOR THE FIRST TIME. IN OTHER WORDS, IT IS VERY POSSIBLE THAT IN THE SAME CASE THE STATE AGENCY DECISION TO DENY BENEFITS AND THE ALJ DECISION TO ALLOW BENEFITS WERE BOTH CORRECT. UNFORTUNATELY, WE HAVE ALSO DISCOVERED A PROBLEM OF INCORRECT DECISIONS BY ALJ'S. UNDER OUR PROGRAM OF OWN-MOTION REVIEW, AS REQUIRED BY THE BELLMON AMENDMENT, THE APPEALS COUNCIL IS NOW REVIEWING 15 PERCENT OF ALJ ALLOWANCE DECISIONS. THIS REVIEW INCLUDES BOTH INITIAL CLAIMS AND CDI CASES. WE ARE FINDING DEFECTS IN 10 PERCENT OF THE DECISIONS WE REVIEW. IN APPROXIMATELY 17 PERCENT OF CASES REVIEWED, THESE ERRORS ARE SO SUBSTANTIAL THAT THE APPEALS COUNCIL MUST EITHER REVERSE THE ALJ'S DECISION OR REMAND THE CASE BACK TO THE ALJ FOR FURTHER ACTION.

SSA'S INITIATIVES TO IMPROVE THE CDI PROCESS

NOW I WOULD LIKE TO TELL YOU ABOUT SOME OF THE ACTIONS WE ARE TAKING TO IMPROVE THE CDI PROCESS. THESE IMPROVEMENTS FALL IN FOUR GENERAL CATEGORIES: (1) THOSE INTENDED TO IMPROVE THE OVERALL CDI PROCESS; (2) THOSE AFFECTING QUALITY CONTROL; (3) THOSE WHICH WILL IMPROVE THE APPELLATE PROCESS; AND (4) MANAGING CASELOADS.

FIRST, WE ARE TRYING TO UPGRADE THE OVERALL CDI PROCESS AS FOLLOWS:

-- WE ARE REFINING OUR SELECTION CRITERIA SO THAT MORE BENEFICIARIES WHO ARE PERMANENTLY DISABLED ARE IDENTIFIED AND EXEMPTED FROM THE 3-YEAR PERIODIC REVIEW PROCESS. IN MARCH, WE IDENTIFIED SEVERAL NEW CATEGORIES OF IMPAIRMENTS--SUCH AS ARTHRITIS OF A MAJOR WEIGHT-BEARING JOINT IN A PERSON AGE 59 OR OVER--WHICH SHOULD BE CONSIDERED PERMANENT AND, AS ADDITIONAL EXPERIENCE IS GAINED, WE EXPECT TO ADD ADDITIONAL IMPAIRMENTS TO THE LIST. THIS HAS CUT DOWN ON THE NUMBER OF REVIEWS AND ALLOWED MORE TIME TO BE SPENT ON EACH CASE.

-- WE NOW REQUIRE STATE AGENCIES TO DEVELOP ALL MEDICAL EVIDENCE OF RECORD LISTED BY THE BENEFICIARY FOR THE PAST 12 MONTHS, RATHER THAN RESTRICTING DEVELOPMENT TO

EVIDENCE WHICH APPEARS PERTINENT TO THE CDI DECISION, OR TO PROVIDE DOCUMENTATION AS TO WHY ALL EVIDENCE LISTED COULD NOT BE OBTAINED.

-- OUR REGIONAL OFFICES ARE WORKING WITH THE STATE AGENCIES TO SET UP MORE EFFECTIVE INTERNAL REVIEWS OF ERROR-PRONE CASES.

-- WE ARE TESTING THE USE OF MULTIPLE CONSULTATIVE MEDICAL EXAMINATIONS IN CERTAIN CASES, PARTICULARLY THOSE INVOLVING PSYCHIATRIC IMPAIRMENTS.

-- WE ARE ENCOURAGING THE STATES TO INCREASE THE NUMBER OF PSYCHIATRISTS ON THEIR STAFFS IN ORDER TO ENHANCE THEIR ABILITY TO REVIEW CASES INVOLVING MENTAL IMPAIRMENTS.

-- SINCE MARCH, WE HAVE REQUIRED THE STATES TO FURNISH MORE DETAILED EXPLANATIONS OF TERMINATION DECISIONS.

-- WE HAVE REVIEWED THE SEVERAL QUESTIONNAIRE FORMS USED IN THE CDI PROCESS AND ARE MAKING CHANGES THAT WILL ELICIT MORE COMPLETE MEDICAL INFORMATION.

-- WE ARE ATTEMPTING TO IMPROVE DECISIONMAKING BY PHYSICIANS EMPLOYED BY SSA AND STATE AGENCIES THROUGH TRAINING, PARTICULARLY TRAINING REGARDING THE

EVALUATION OF PSYCHIATRIC IMPAIRMENTS AND AN INDIVIDUAL'S REMAINING CAPACITY TO WORK.

SECOND, WE ARE TRYING TO IMPROVE QUALITY CONTROL THROUGH THE FOLLOWING EFFORTS:

-- AS PART OF OUR QUALITY CONTROL PROCESS WE REVIEW A SAMPLE OF CDI CASES AFTER A DECISION HAS BEEN REACHED AS TO WHETHER THE DISABILITY IS CONTINUING OR HAS CEASED. TO IMPROVE THIS PROCEDURE WE ARE TAKING TWO STEPS: (1) IN TERMINATION CASES, WE ARE CONDUCTING THE QUALITY REVIEW BEFORE BENEFITS ARE STOPPED, AND (2) WE HAVE DOUBLED THE NUMBER OF QUALITY REVIEWS OF TERMINATION CASES--FROM 13,500 CASES ANNUALLY TO 27,000.

-- IN OUR QUALITY REVIEW PROCESS, WE WILL STUDY TERMINATIONS TO ASCERTAIN WHAT KINDS ARE ESPECIALLY ERROR-PRONE, AND SUBJECT THESE KINDS OF CASES TO A MORE INTENSIVE REVIEW BEFORE A FINAL DECISION IS MADE. THIS SHOULD ENABLE US TO PREVENT MORE OF THESE ERRORS IN THE FUTURE.

THE THIRD AREA WHERE WE ARE MAKING IMPROVEMENTS IS IN THE CDI APPELLATE PROCESS:

-- IN GENERAL, WE ARE DETERMINING THAT A DISABILITY HAS TERMINATED AS OF THE DATE THE BENEFICIARY IS NOTIFIED OF THE TERMINATION.

-- WE ARE GIVING PRIORITY TO APPEAL REQUESTS IN TERMINATION CASES.

-- WE HAVE HIRED MORE THAN 100 ADDITIONAL ALJ'S THIS YEAR, INCREASING THE SIZE OF THE CORPS TO 800. WE ARE ALSO INCREASING THE RATIO OF SUPPORT STAFF TO THE ALJ'S FROM THE PAST LEVEL OF APPROXIMATELY FOUR TO ONE TO A RATIO OF FIVE TO ONE.

-- THROUGH IMPROVED TRAINING, UPGRADED EQUIPMENT, AND NEW WORKFLOW AND ORGANIZATIONAL ARRANGEMENTS, WE ARE INCREASING THE PRODUCTIVITY OF HEARING OFFICES.

FINALLY, WE HAVE CONTINUOUSLY MONITORED STATE AGENCY RESOURCES AND WORKLOADS TO ADJUST THE FLOW OF CASES AS NECESSARY.

-- SOME STATE AGENCIES HAVE HAD PROBLEMS ACQUIRING ADEQUATE RESOURCES IN A TIMELY FASHION. WHERE BACKLOGS HAVE RISEN BECAUSE OF CIRCUMSTANCES BEYOND THE AGENCY'S CONTROL, WE HAVE REDUCED THE FLOW OF CASES. THESE STATE AGENCIES INCLUDED MAINE, PUERTO RICO, UTAH, NEW JERSEY AND INDIANA.

-- August is traditionally a month with high vacation rates. So that all States would have an opportunity to get caseloads under control while so many personnel are on vacation, SSA released only one-third of the normal volume of cases for review in August.

-- In September, 17 States still will not receive cases so that they can reduce backlogs.

-- As a result of these adjustments, we estimate that we will process 506,000 continuing disability cases in fiscal year 1982 rather than the 567,000 previously planned.

-- As a result of the experience gained since March 1981 and the initiatives just described to improve the CDI process, SSA expects to be able to reduce the numbers of cases that have to be reviewed in FY 1983 to meet the mandate of the law.

PENDING LEGISLATION

Next, I would like to talk about legislation pending in the Congress that addresses the CDI process. As you know, H.R. 6181 was approved by the House Ways and Means Committee on May 19. The Administration supports H.R. 6181 with the exception of three provisions--sections 3, 9, and 12. These sections would:

(1) INCREASE THE COSTS OF THE SOCIAL SECURITY SYSTEM BY EXTENDING DISABILITY BENEFITS FOR AN ADDITIONAL 4 MONTHS FOR THOSE PEOPLE WHO HAVE COLLECTED BENEFITS FOR 3 OR MORE YEARS AND WERE TERMINATED BECAUSE OF MEDICAL RECOVERY; (2) RESTRICT PROGRAM DISCRETION BY AUTOMATICALLY INDEXING THE SUBSTANTIAL GAINFUL ACTIVITY LEVEL USED IN DETERMINING ELIGIBILITY FOR DI AND SSI BENEFITS; AND (3) UNNECESSARILY EXPAND VOCATIONAL REHABILITATION SERVICES FOR WHICH FEDERAL FUNDS CAN BE USED.

IN ADDITION TO H.R. 5181, BILLS ADDRESSING THE CDI PROCESS HAVE ALSO BEEN INTRODUCED IN THE SENATE. SOME OF THOSE BILLS CONTAIN PROVISIONS SIMILAR TO THE PROVISIONS OF H.R. 5181 WHICH WE SUPPORT, AND WE CONSIDER THESE PROVISIONS TO BE REASONABLE AND CONSTRUCTIVE. WE BELIEVE THAT SSA'S ADMINISTRATIVE INITIATIVES TOGETHER WITH LEGISLATIVE IMPROVEMENTS SUCH AS THOSE I HAVE JUST MENTIONED REPRESENT A STRONG TWO-PRONGED ATTACK ON THE SERIOUS DISABILITY PROBLEMS THAT I HAVE BEEN DISCUSSING TODAY. I LOOK FORWARD TO WORKING WITH THIS COMMITTEE AND THE CONGRESS ON CONSTRUCTING AN EFFECTIVE LEGISLATIVE PACKAGE TO IMPROVE THE DISABILITY PROGRAM.

CONCLUSION

IN CONCLUSION, MR. CHAIRMAN, I WOULD LIKE TO REITERATE THE FACT THAT THE PERIODIC REVIEW PROCESS IS PART AND PARCEL OF OUR ONGOING MISSION TO ENSURE THAT DISABILITY BENEFITS ARE PAID ONLY TO THOSE INDIVIDUALS WHO MEET THE CRITERIA ESTABLISHED IN THE

LAW. THE PERIODIC REVIEW PROCESS HAS EMERGED FROM CONCERN, ON THE PARTS OF THE CONGRESS, GAO, AND ADMINISTRATIONS OF BOTH PARTIES, THAT HUGE SUMS ARE BEING INCORRECTLY PAID TO INDIVIDUALS WHO ARE NOT ELIGIBLE FOR SUCH PAYMENT.

IN THE VAST MAJORITY OF CASES, THE REASON PEOPLE ARE BEING TAKEN OFF THE ROLLS IS NOT BECAUSE OF DEFICIENCIES IN THE PROCESS, BUT BECAUSE THEY ARE NOT DISABLED UNDER THE TERMS OF THE LAW--MANY OF THEM WERE ON THE ROLLS ERRONEOUSLY TO BEGIN WITH AND MANY OF THEM RECOVERED AFTER THEY CAME ON THE ROLLS. WE ARE NOW PAYING THE PRICE BECAUSE THE NECESSARY EMPHASIS WAS NOT PUT ON QUALITY IN ORIGINAL DECISIONS AND THERE WAS NOT A STRONG ONGOING PROGRAM FOR REVIEWING THE EXISTING DISABILITY ROLLS. ONCE WE COMPLETE OUR REVIEW OF THE EXISTING DISABILITY ROLLS AND WE MAINTAIN HIGH QUALITY IN THE INITIAL DETERMINATION AND APPEAL PROCESS, THE PROPORTION OF TERMINATED BENEFICIARIES SHOULD DECLINE.

THERE IS NO QUESTION THAT SOME MISTAKES HAVE BEEN MADE AND, UNFORTUNATELY, EVEN IF OUR ACCURACY RATE IMPROVES, IT IS UNREASONABLE TO EXPECT THAT WE WILL REACH PERFECTION. IN A PROGRAM AS LARGE AS THE DISABILITY PROGRAM EVEN A SMALL PERCENTAGE OF ERROR TRANSLATES INTO A SUBSTANTIAL NUMBER OF CASES. WE WILL CONTINUE TO DO OUR BEST TO IMPROVE OUR ACCURACY RATE.

I WILL NOW BE GLAD TO ANSWER ANY QUESTIONS WHICH YOU OR THE COMMITTEE MEMBERS MAY HAVE.

SSA Actions Taken to Improve Management of Consultative Examinations

Listed below are brief summaries of a wide range of actions taken to improve consultative examinations (CE's). These actions have been directed toward providing clear program direction on CE report requirements and maintenance of a quality process as well as establishing a more formal program of monitoring State agencies in this area.

- Basic SSA policy was issued in Social Security Ruling 82-14, which covered CE physician qualifications, independence of CE physicians from other program or claimant relationships, content of CE reports, and physician signatures on CE reports.

- Detailed instructions have been issued to State agencies in the SSA Program Operations Manual in order to achieve improved CE reports nationally. These instructions cover a broad range of aspects of the CE process including:

    - Selection of CE sources

    - Arrangements for a CE, including provision of pertinent materials in file

    - Report content and signature requirements

    - Guidelines for review of CE reports

    - Specific medical specialty report requirements

- In the initial monitoring by SSA of State agency CE management processes, all States provided general descriptions of their practices for oversight of CE's as well as specific data on the "top ten" providers. These responses were analyzed and weaknesses in handling complaints, keeping records, maintaining ongoing oversight and other areas were identified. Regional Commissioners (RC'S) then worked with each State to improve oversight. Followup reports have now been submitted from all regions.

- In the second stage of SSA monitoring efforts, an indepth protocol was developed for reviewing all aspects of a CE provider's operation and the State agency's oversight of it. Joint SSA-State onsite reviews of 30 CE providers were completed by the end of April.

- Administrative guidelines were issued to State agencies in a Fiscal and Administrative Letter (FAL). These specify what States must do in their oversight of CE providers. In addition, specific instructions are being issued to RC'S regarding the need to monitor State agency compliance with the administrative guidelines.

- State agency administrators and staff from 45 Disability Determination Services (DDS's) attended the first disability programs management forum in March. The forum included a series of workshops designed to allow administrators to share problems and solutions for managing the CE process.

- Additional technical policy guidelines will be issued in the near future. Such issues as whether CE providers are bound by the Privacy Act and how CE providers should respond to requests for interrogatories by claimant's attorneys have been raised as we have explored the complaints of the legal community concerning CE providers.

- We are developing a methodology for review and comparison of CE providers through the case review process. At present, review procedures do not provide for the sampling of cases by CE provider nor are we certain what can be learned from case reviews targeted by CE provider. Studies will be geared to determine whether there are significant differences between CE's done by volume providers and those done by other sources. This is scheduled to begin in September.

- We are providing the Regional Offices (RO's) with reports of providers suspended or terminated by Health Care and Financing Administration (HCFA) for fraud or abuse of federal funds.

- The States were surveyed to determine whether it would be advantageous to negotiate fee schedules with large CE providers. Because of poor public perception it was deemed not desirable/advantageous.

- A summary analysis is being prepared for each region of what was learned on the onsite reviews and to critique the reviews intraregion.

- A central reference file is being developed to coordinate claimant/physician/attorney complaints and to coordinate responses and information with the regions.

Senator ARMSTRONG. Thank you, Mr. Commissioner.

I suspect that there are some members of the committee that would like to direct some questions to you.

Senator Heinz, did you have some questions you wanted to raise?

Senator HEINZ. Yes, Mr. Chairman, I do. I have a lot of questions, and I am going to submit some of them for the record, but there is one area in particular I want to get into.

Mr. Simmons, in your statement here today you said that the Social Security Administration was essentially purging improperly designated individuals from the rolls. Indeed, it is not the first time you have said that; on April 28, 1982, you had a letter to the editor published in the Philadelphia Inquirer, the largest newspaper in my State. You explained, and I quote:

> Our intent is to review individual cases—some of which haven't been reviewed in 15 years—to determine if the individual's medical condition has improved to the point that it is possible to return to work.

Would you say that everybody who is being terminated has improved medically?

Mr. SIMMONS. Well, the medical improvement issue is, I think, a separable issue from what the problem is now in the program.

First of all the law says that if you are able to do substantial gainful work anywhere in the economy in any kind of a job, then you are not eligible for disability insurance. That is the definition in the law.

There are many people on the rolls, for example, who came on, say in the mid-1970's, when it was almost an open door policy because of the SSI crush, who may have had one cardiovascular incident or something similar, for which there are now pills and therapies available which weren't even available then. There are many cases like that.

Senator HEINZ. Well, I'll get to those. I'm just trying to establish a simple fact.

Mr. SIMMONS. No, the review is focused on the question as posed in the law: Is this person able to do any kind of work which would be called "substantial gainful activity" in the economy?

Senator HEINZ. I understand that, but my question to you, which is a different question from the answer you are giving, is: Do you maintain that the people you are removing have improved medically?

Mr. SIMMONS. Not if you are defining medically as "any condition that might have been at risk when the person went on the rolls is now still present in the same degree," no.

Senator HEINZ. So you are terminating people who have not improved medically. Is that correct?

Mr. SIMMONS. That is correct, sir, in your definition.

Senator HEINZ. What proportion of terminations involve people who have not improved medically?

Mr. SIMMONS. I don't know if we have an exact number. No; we do not have an exact number or a percentage.

Senator HEINZ. You have no idea?

Mr. SIMMONS. We have estimated that 51 percent of those terminated experienced medical improvement. One of the reasons that we don't have more than an estimate is that the test is: Is that person able to work somewhere in the economy? So, therefore we don't collect statistics on the condition of each person past and present.

Senator HEINZ. Well, didn't you do a CDI redesign sample study?

Mr. SIMMONS. I would ask Ms. Greenberg to talk about that study.

Senator HEINZ. Is it not the case you did such a study and that it showed that at least 35 percent of the people you have been terminating were either the same or worse?

Ms. GREENBERG. I don't remember that finding, Senator. Maybe Ms. Bedwell does.

Ms. BEDWELL. Yes: that's right.

Senator HEINZ. All right.

Now, I gather what you really are saying is that there are people who shouldn't have been put on the rolls in the first place. Is that right?

Mr. SIMMONS. There are many cases like that, and there are many cases of people who maybe should have been put on the rolls at the time, given the state of medical technology, but now are no longer in the same situation.

Senator HEINZ. Now, what standards are you using when you say those people should never have been put on the rolls in the first place? Are you using the standards that they were judged against at the time, or are you using some new standard that has come along since?

Mr. SIMMONS. There are many cases where, if you looked up the standard they were judged against at the time, they may well have qualified, because of the nature of the medical technology and because of the philosophy of the program. But some of those same people might not qualify now, considering what is available—kidney transplants, drugs, mood drugs, and all kinds of things that can be used to control conditions that used to be all but hopeless or used to be really debilitating. As the GAO pointed out in 1981 there were an incredible number of people who were on those rolls who really did not belong there under the 1980 standards even, and that's one of the reasons why the periodic review provision was included in the 1980 disability amendments.

Senator HEINZ. Well, let's just be clear on something. You are saying two things. A few minutes ago you said those people shouldn't have been put on the rolls in the first place.

Mr. SIMMONS. There are many who should not have been, because at the time of the SSI program, for example, the incidence rate on disability went way up, and if you look at the charts in your blue book prepared by the staff you can see the incidence rates going way up in the mid-1970's and then dropping sharply, because during that period they were being put on the rolls almost on a first-come, first-served basis—and I know; I was a State welfare commissioner.

Senator HEINZ. Now, let's just examine that for a minute. On the other hand, you said that to the best of your understanding, unless I misheard you, people were being put on the rolls in accordance with then existing law.

Mr. SIMMONS. Not every person at that time was put on in strict accordance with the law.

Senator HEINZ. Do you think most were, though?

Mr. SIMMONS. I would not characterize what the error rate might have been in that period, because there were several States that were contributing to that by loading up their State rolls before having them taken over by SSI. But I will say that probably a significant number at that time. I don't think there were good, quality assurance samples taken at that time.

Senator HEINZ. Well, I'm sure my time has expired. I will just make the following observation: It appears to me that when we talk about these redeterminations, when we talk about people having gotten on the rolls in the first place that shouldn't have, certainly there are some people who shouldn't have gotten on the rolls in the first place; but it is also true that an awful lot of the people who you are terminating were put on the rolls in accordance with properly applied standards as were then in effect.

Secondly, it is my understanding that there have been substantial changes since 1979 in the medical listings, that at the subregulatory level, the State level, the POMS used by the State agencies change from month to month, and in some cases from week to week. Meanwhile, the statutory definition of disability hasn't been changed since the mid-1960's. Now, everything you have referred to has been in the 1970's and 1980's, and there has been no change in the statute since 1965 and 1967. So I must say I have real problems with what you are doing. It seems to me that when you say, or I suspect you would say, that the medical improvement standard that a number of us favor is going to be some kind of a cost, that it may not get you as much savings as you want, I fail to see where in the law we have abandoned the medical improvement standard.

Mr. SIMMONS. Well, to adopt a medical improvement standard of the kind we are talking about would be really unfair to the person today who is not on the disability rolls because he can't qualify for the disability rolls, because he is using the therapy which could treat the person who was already on the rolls. What you would be doing, in effect, would be grandfathering a lot of people who probably could work in the economy.

Senator HEINZ. Well, it depends on which medical improvement standard you use. Now, Senator Levin's and Senator Cohen's bill has a strict medical improvement standard in it. My bill is a little bit different; we allow for improvements in medical technology.

Mr. SIMMONS. Well, improvements in medical technology are what drive what you have characterized as the almost "month-to-month" changes in the standards.

If you put something into a law that says we have to show medical improvement, and all that, and then as a companion piece, which I've seen in some of these bills, that says any new standard would have to be published as rulemaking—which takes a year to a year and a half——

Senator HEINZ. Would you support a medical improvement standard which took into account changes in medical technology?

Mr. SIMMONS. No, sir, we could not. We think that changes in medical technology are already being taken into account in an appropriate manner under current law; this can be done administratively. We think it is being done, in effect, administratively, I would point out that the changes that are made in the adjudicative standards are reflective of medical technology. Twenty years ago a person might considered disabled with a single heart attack. Today such a person might be back to work in 12 or 13 weeks. You can't lock into the law and you can't lock into practice some mechanism that causes you to go to rulemaking every time somebody invents a new pill.

For example, I read in the papers that we are on the verge of a big breakthrough in allergy medicine. What if we had to wait a year and a half to adopt that standard?

Senator HEINZ. Mr. Commissioner, I am not trying to get into a lengthy debate on this; I just want it to be clear that I didn't mention that we were going to lock into statute all the things you have just said or apply the Administrative Procedures Act in the way you have just suggested. It's not written into in my bill that way; and I want to correct any implication that that's the way it is written in my bill.

Mr. SIMMONS. I did not mean to characterize your bill that way; I said we have seen that in several other versions.

Senator ARMSTRONG. Senator Chafee, what do you say to all this?

Senator CHAFEE. Well, thank you, Mr. Chairman.

Mr. Simmons, I would like to ask you: If the system is working successfully, as you portray it, why is it that your own appointed ALJ's are overruling 66 percent of the cases?

Mr. SIMMONS. This is a problem which has been chronic within the system and which is being addressed in the House bill and in some of the bills that are pending before this committee now. There has been a dichotomy that has grown over the years between the way the ALJ's perceive their role in the system and the way they interpret the law and the way the law is interpreted in the standards that the State agencies administer. And we are issuing the standards Commissioners' rulings, as social security rulings, which will allow us to change them as medical technology advances and which would hold one and all in the adjudicatory system to the same standards so that a person going into the system knows what the ground rules are. One of the problems we have now is that they don't.

Senator CHAFEE. I only have a few minutes here, so these answers have got to be fairly crisp. As I get the picture, what you are saying is that your ALJ's have gotten into bad habits. Is that the suggestion?

Mr. SIMMONS. Let me ask Mr. Hays, who is the Associate Commissioner for Hearings and Appeals, to address that.

Mr. HAYS. First, Senator, I would like to note for the record that the current allowance rate on these cessation cases by our administrative law judges is running 60 percent, not at the higher 66 or 67 percent.

Secondly, I would also like to point out——

Senator CHAFEE. I don't want to let that go back just without an argument. So you win; it is not 67, it is 60. But I think a 60 percent overruling is imposing on an appellant a terrible burden.

Mr. HAYS. The figure is obviously high.

Senator CHAFEE. Whatever it is, it is not a very happy figure.

Mr. HAYS. In addition to Mr. Simmons' comments I would also note that it is very possible in a single case that the State agency's decision to deny benefits and the administrative law judge's decision to grant benefits could be correct because of the lapse in time between the time that the case is handled at the State agency level and the time that the administrative law judge makes the decision. The condition may have changed, may have gotten worse, there might be additional impairments; there may be additional evidence.

Senator CHAFEE. Well, I don't think that's much of an explanation, either; because, as I understand, under the current system the person's benefits are terminated at the time the decision is made at the State level. So you are saying a lot has happened in the interim. If so much time has gone by that the person has had a miraculous cure or a setback, he or she has also been without the benefits for a long time.

Mr. SIMMONS. But there are two reasons we are supporting the Ways and Means Committee bill: One is that it lengthens the reconsideration appeal process to 6 months and pays benefits through that; number two, and most importantly, it adds an evidentiary, face-to-face hearing at that stage. We think that far fewer cases would go on to the ALJ level if these two provisions were written into the law, and it would make the reconsideration process much better because it would give the person a face-to-face opportunity to make his or her case early on in the process. Sometimes the face-to-face confrontation is crucial to an ALJ's decision, and understandably so.

Senator CHAFEE. Well, I would think so. I think it is fairly important to be able to see the petitioner.

You mentioned you were supporting the Ways and Means legislation. Do you have legislation you are particularly supporting? Are you supporting some entire measure that is before the Ways and Means Committee?

Mr. SIMMONS. Yes. We are supporting all but three provisions of the House bill, and we have worked with the committee very closely on drafting the bill. They were the first to move—that's why we were over there working with them. We have been very cooperative with them, and we have a piece of legislation which we think has great promise, and we would like to see major elements of that enacted into law.

Senator CHAFEE. Well, I think we would like to see a copy of that with the items that you do not support. It would give us a better feel of what the administration believes in. If you could send that up to the committee, I would appreciate it.

[The following was subsequently supplied:]

We support H.R. 6181 with the exception of three provisions--sections 3, 9 and 12. These sections would:

(1) increase the costs of the Social Security system by extending disability benefits for an additional 4 months for those people who have collected benefits for 3 or more years and were terminated because of medical recovery;

(2) restrict program discretion by automatically indexing the substantial gainful activity level to be used in determining eligibility for DI and SSI benefits; and

(3) unnecessarily expand vocational rehabilitation services for which Federal funds can be used.

A copy of H.R. 6181 as approved by the Committee on Ways and Means is attached.

I

Union Calendar No. 361

97TH CONGRESS
2D SESSION

H. R. 6181

[Report No. 97-588]

To amend title II of the Social Security Act to provide adjustment benefits, vocational training, and waiver of overpayments for individuals terminated from the disability program, to strengthen the reconsideration process by providing for the earlier introduction of evidence of record, to provide for more uniformity in decisionmaking at all levels of adjudication, and for other purposes.

IN THE HOUSE OF REPRESENTATIVES

APRIL 28, 1982

Mr. PICKLE (for himself and Mr. ARCHER) introduced the following bill; which was referred to the Committee on Ways and Means

MAY 26, 1982

Additional sponsors: Mr. SKELTON, Mr. JONES of North Carolina, Mr. SMITH of New Jersey, Mr. WEBER of Ohio, Mr. MITCHELL of New York, Mrs. BOUQUARD, Mr. HUTTO, and Mr. SMITH of Alabama

MAY 26, 1982

Reported with amendments, committed to the Committee of the Whole House on the State of the Union, and ordered to be printed

[Omit the part struck through and insert the part printed in italic]

A BILL

To amend title II of the Social Security Act to provide adjustment benefits, vocational training, and waiver of overpayments for individuals terminated from the disability program, to strengthen the reconsideration process by providing for the earlier introduction of evidence of record, to provide for more uniformity in decisionmaking at all levels of adjudication, and for other purposes.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled, That this Act, with the following table of contents, may be cited as the "Disability Amendments of 1982".

TABLE OF CONTENTS

Sec. 1. Short title.
Sec. 2. Continued payment of disability benefits during appeal.
Sec. 3. Adjustment benefits.
Sec. 4. Benefit payments not to be treated as overpayments in certain cases.
Sec. 5. Closing of the record on applications involving determinations of disability; disability decisions, appeals, and review.
Sec. 6. Own motion review; review of State agency determinations.
Sec. 7. Standards for disability determinations.
Sec. 8. Evaluation of pain.
Sec. 9. Substantial gainful activity and trial work.
Sec. 10. Prohibition against interim benefits.
Sec. 11. Amendments relating to reduction in disability insurance benefits on account of other related payments.
Sec. 12. Payment of costs of rehabilitation services from trust funds; experiments and demonstration projects.

CONTINUED PAYMENT OF DISABILITY BENEFITS DURING APPEAL

SEC. 2. (a) Section 223 of the Social Security Act is amended by adding at the end thereof the following new subsection:

"Continued Payment of Benefits During Appeal

"(g)(1) In any case where—

"(A) an individual is a recipient of disability insurance benefits, or of child's, widow's, or widower's insurance benefits based on disability, "(B) the physical or mental impairment on the basis of which such benefits are payable is found to have ceased or not to have existed (or to be no longer disabling), and as a consequence such individual is determined not to be entitled to such benefits, and

"(C) a timely request for reconsideration of the determination that he is not so entitled is made under section 221(d)(1),

such individual may elect (in such manner and form and within such time as the Secretary shall by regulations prescribe) to have the payment of such benefits, and the payment of any other benefits *under this Act* based on such individual's wages and self-employment income, continued for an additional period beginning with the first month for which (under such determination) such benefits are no longer otherwise payable and ending with the month preceding the month in which a decision is made upon such reconsideration or (if earlier) with the sixth month after the month in which he was initially notified in writing (by the applicable State agency or the Secretary) of such determination.

"(2) If an individual elects to have the payment of his benefits continued for an additional period under paragraph (1) pending reconsideration, and the decision upon such reconsideration affirms the determination that he is not entitled to such benefits, any benefits paid *under this title* pursuant to such election (for months in such additional period) shall be considered overpayments for all the purposes of this title.

"(3) If any month in the additional period during which benefits are payable to an individual pursuant to an election under paragraph (1) is a month for which an adjustment benefit (of the type involved) is also payable to such individual under subsection (a)(3), the benefit which is paid to him *under this title* for such month shall be deemed to be an adjustment benefit under such subsection (a)(3) rather than a benefit payable pursuant to such election under paragraph (1).".

(b)(1) Subject to paragraph (2), the amendment made by subsection (a) shall apply with respect to determinations (that individuals are not entitled to benefits) which are made on or after the date of the enactment of this Act.

(2) Effective January 1, 1984, section 223(g)(1) of the Social Security Act (as added by subsection (a) of this section) is amended by striking out "or (if earlier) until the close of the sixth month after the month in which he was initially notified in writing (by the applicable State agency or the Secretary) of such determination".

ADJUSTMENT BENEFITS

SEC. 3. (a) Section 223(a) of the Social Security Act is amended by adding at the end thereof the following new paragraph:

"(3)(A) In any case where—

"(i) an individual is a recipient of disability insurance benefits, or of child's, widow's, or widower's insurance benefits based on disability, and has been a recipient of such benefits for a period of not less than 36 consecutive months, and

"(ii) the physical or mental impairment on the basis of which such benefits are payable is found to have ceased or not to have existed (or to be no longer disabling), and as a consequence such individual is determined, on or after the date of the enactment of this paragraph and before January 1, 1985, not to be entitled to such benefits,

such individual shall be entitled (subject to subparagraph (B)) to have the payment of such benefits, and the payment of any other benefits *under this Act* based on such individual's wages and self-employment income, continued for an additional period of four months, beginning with the first month for which (under such determination) such benefits are no longer otherwise payable or (if later) with the month in which he is initially notified in writing (by the applicable State agency or the Secretary) of such determination.

"(B) No benefit shall be payable to any individual (or to any other person on the basis of such individual's wages and self-employment income) under subparagraph (A) for any month in the additional period referred to in such subparagraph if—

"(i) such individual is determined by the Secretary to have engaged in substantial gainful activity in that month, or

"(ii) such individual (or other person) is entitled or would upon application be entitled, for such month, to a monthly benefit of any other type under this title.".

(b)(1) The first sentence of section 223(a)(1) of such Act is amended by striking out "and ending with the month" and inserting in lieu thereof "and ending (subject to paragraph (3) of this subsection and to subsections (g) and (h)) with the month".

(2)(A) Subsections (b)(1), (c)(1), (d)(1), (e)(1), and (f)(1) of section 202 of such Act are each amended by striking out "and ending with the month" and inserting in lieu thereof "and ending (subject to subsections (a)(3), (g), and (h) of section 223) with the month".

(B) Subsection (d)(6) of such section 202 is amended by striking out "shall end with the month" and inserting in lieu thereof "shall end (subject to subsections (a)(3), (g), and (h) of section 223) with the month".

(3) Section 216(i)(2) of such Act is amended—

(A) by striking out "shall end" in subparagraph (D) and inserting in lieu thereof "shall (subject to subparagraph (H)) end"; and

(B) by adding at the end thereof the following new subparagraph:

"(H) The provisions of subsections (a)(3), (g), and (h) of section 223 shall apply with respect to the duration of an individual's period of disability under this subsection in the same way that they apply with respect to the duration of the period for which an individual's disability insurance benefits are payable under such section 223.".

(c) Section 1631(a) of such Act is amended by adding at the end thereof the following new paragraph:

"(7)(A) In any case where—

"(i) an individual who is an aged, blind, or disabled individual solely by reason of blindness (as determined under section 1614(a)(2)) or disability (as determined under section 1614(a)(3)) has been a recipient of benefits under this title for a period of not less than 36 consecutive months, and

"(ii) the impairment on the basis of which such benefits are payable is found to have ceased or not to have existed (or to be no longer disabling), and as a consequence such individual is determined, on or after the date of the enactment of this paragraph (or October

1, 1982, if later) and before January 1, 1985, not to be eligible for such benefits,

such individual shall be entitled (subject to subparagraph (B)) to have the payment of such benefits continued for an additional period of four months, beginning with the first month for which (under such determination) such benefits are no longer otherwise payable under this title or (if later) with the month in which he is initially notified in writing (by the applicable State agency or the Secretary) of such determination.

"(B) No benefit shall be payable to any individual under subparagraph (A) for any month in the additional period referred to in such subparagraph if such individual is determined by the Secretary to have engaged in substantial gainful activity in that month.".

BENEFIT PAYMENTS NOT TO BE TREATED AS OVERPAYMENTS IN CERTAIN CASES

SEC. 4. (a) Section 223 of the Social Security Act (as amended by section 2(a) of this Act) is further amended by adding at the end thereof the following new subsection:

"Benefit Payments Not To Be Treated as Overpayments in Certain Cases

"(h) Notwithstanding any other provision of this title, in any case where—

"(1) an individual is a recipient of disability insurance benefits, or of child's, widow's, or widower's insurance benefits based on disability, and

"(2) the physical or mental impairment on the basis of which such benefits are payable is found to have ceased or not to have existed (or to be no longer disabling), and as a consequence such individual is determined, on or after the date of the enactment of this subsection and before January 1, 1985, not to be entitled to such benefits,

no such benefit which was paid to such individual for any month prior to the month in which he is initially notified in writing (by the applicable State agency or the Secretary) of such determination, and no benefit which was paid *under this Act* to any other person for any such month on the basis of such individual's wages and self-employment income, shall be considered an overpayment for any of the purposes of this title.".

(b) Section 223(g)(2) of such Act (as added by section 2(a) of this Act) is amended by striking out "If an individual" and inserting in lieu thereof "Subject to subsection (h), if an individual".

(c) Section 1631(b) of such Act is amended by redesignating paragraph (3) as paragraph (4) and by inserting after paragraph (2) the following new paragraph:

"(3) Notwithstanding any other provision of this title, in any case where—

"(A) an individual who is an aged, blind, or disabled individual solely by reason of blindness (as determined under section 1614(a)(2)) or disability (as determined under section 1614(a)(3)) is a recipient of benefits under this title, and

"(B) the impairment on the basis of which such benefits are payable is found to have ceased or not to have existed (or to be no longer disabling), and as a consequence such individual is determined, on or after the date of the enactment of this subsection (or October 1, 1982, if later) and before January 1, 1985, not to be eligible for such benefits,

no such benefit which was paid to such individual for any month prior to the month in which he is initially notified in writing (by the applicable State agency or the Secretary) of such determination shall be considered an overpayment for any of the purposes of this title.".

CLOSING OF THE RECORD ON APPLICATIONS INVOLVING DETERMINATIONS OF DISABILITY; DISABILITY DECISIONS, APPEALS, AND REVIEW

SEC. 5. (a)(1) Section 202(j)(2) of the Social Security Act is amended to read as follows:

"(2) An application for any monthly benefits under this section filed before the first month in which the applicant satisfies the requirements for such benefits shall be deemed a valid application (and shall be deemed to have been filed in such first month) only if the applicant satisfies the requirements for such benefits before the Secretary makes a final decision on the application and—

"(A) no request under section 205(b) for notice and opportunity for a hearing thereon is made or, if such a request is made, before a decision based upon the evidence adduced at the hearing is made (regardless of whether such decision becomes the final decision of the Secretary), and

"(B) in the case of an applicant with respect to whom disability is required for such benefits under subsection (d)(1)(B)(ii), (e)(1)(B)(ii), or (f)(1)(B)(ii), no request for reconsideration under section 221(d) is made, or if such a request is made, subject to section 221(d)(5), before a decision on reconsideration is made under section 221(d).".

(2) Section 216(i)(2)(G) of such Act is amended by striking out "and no request" and all that follows and inserting in lieu thereof the following: "and no request for reconsideration under section 221(d) is made, or if such a request is made,

subject to section 221(d)(5), before a decision on reconsideration is made under section 221(d).".

(3) Section 223(b) of such Act is amended by striking out "and no request" and all that follows down through the end of the first sentence and inserting in lieu thereof the following: "and no request under section 221(d) is made, or if such a request is made, subject to section 221(d)(5), before a decision on reconsideration is made under section 221(d).".

(b) Section 205(b) of such Act is amended to read as follows:

"(b)(1) The Secretary is directed to make findings of fact and decisions as to the rights of any individual applying for a payment under this title.

"(2)(A) The Secretary may provide for reconsideration of such decisions (other than decisions to which subparagraph (B) applies) and shall provide for hearings in accordance with paragraph (3).

"(B) If the determinations required in the course of making any such decision include a determination relating to disability or to a period of disability and such decision is in whole or in part unfavorable to an individual applying for a payment under this title, the Secretary shall provide for reconsideration of such decision and for hearings in accordance with section 221.

"(3) Upon request by any individual applying for a payment under this title or upon request by a wife, divorced wife, widow, surviving divorced wife, surviving divorced mother, husband, widower, child, or parent who makes a showing in writing that his or her rights may be prejudiced by any decision the Secretary has rendered (other than a decision to which paragraph (2)(B) applies), he shall give such applicant and such other individual reasonable notice and opportunity for a hearing with respect to such decision, and, if a hearing is held, shall, on the basis of evidence adduced at the hearing, affirm, modify, or reverse his findings of fact and such decision. Any such request with respect to any such determination must be filed within sixty days after notice of the decision is received by the individual making such request.

"(4) The Secretary is further authorized, on his own motion, to hold such hearings and to conduct such investigations and other proceedings as he may deem necessary or proper for the administration of this section, section 221, and the other provisions of this title.

"(5) In the course of any hearing, investigation, or other proceeding referred to in paragraph (4), the Secretary may administer oaths and affirmations, examine witnesses, and receive evidence.

"(6) Evidence may be received at any hearing referred to in paragraph (4), subject to section 221(d)(5), even though inadmissible under rules of evidence applicable to court procedure.

"(7) Subject to the specific provisions and requirements of this Act—

"(A) any hearing held pursuant to this subsection or section 221(e) shall be conducted on the record and shall be subject to sections 554 through 557 of title 5, United States Code, and any decision made by the Secretary after such a hearing shall constitute an 'adjudication' within the meaning of section 551(7) of such title; and

"(B) the Secretary, in accordance with section 3105 of title 5, United States Code, shall appoint administrative law judges who, in any case in which authority to conduct hearings under this subsection or section 221(e) is delegated by the Secretary, shall conduct such hearings, issue decisions after such hearings, and perform such other functions and duties described in sections 554 and 557 of such title as are applicable to such hearings.".

~~(e) Section 205(g) of such Act is amended—~~

~~(1) in the fourth sentence, by striking out ", with or without remanding the case for a rehearing" and inserting in lieu thereof "without any remand of the case"; and~~

~~(2) by striking out the sixth and seventh sentences.~~

~~(d)(1)~~ *(c)(1)* Section 221 of such Act is amended—

(A) by striking out the heading and inserting in lieu thereof "DISABILITY DETERMINATIONS, APPEALS, AND REVIEW";

(B) by redesignating subsections (d), (e), (f), (g), and (i) as subsections (f), (g), (h), (i), and (j), respectively; and

(C) by inserting after subsection (c) the following new subsections:

"(d)(1) Any initial decision the Secretary renders with respect to an individual's rights for a payment under this title (including a decision the Secretary renders by reason of a review under subsection (c)) in the course of which a determination relating to disability or to a period of disability is required for such payment and which is in whole or in part unfavorable to such individual shall contain a statement of the case, in understandable language, setting forth a discussion of the evidence, the Secretary's decision, and the reason or reasons upon which the decision is based. Upon request by any such individual, or by a wife, divorced wife, widow, surviving divorced wife, surviving divorced mother, husband, widower, child, or parent, who makes a showing in writing that his or her rights may be prejudiced by such a decision, he or she shall be entitled to reconsideration of such decision under this subsection. Any such request with respect to any such decision must be filed within 180 days after notice of the decision is received by the individual making such request.

"(2)(A) If a reconsideration is requested by an individual under paragraph (1) and a showing is made by such individual that he or she may be prejudiced in such decision by a determination relating to disability or to a period of disability, such individual shall be entitled in the course of such reconsideration to a determination relating to such disability or period of disability.

"(B)(i) In the case of a reconsideration to be made by the Secretary of a decision to terminate benefits in which a determination relating to disability or to a period of disability was made by a State agency, any determination under subparagraph (A) relating to disability or to a period of disability shall be made by the State agency, notwithstanding any other provision of law, in any State that notifies the Secretary in writing that it wishes to make determinations under this subparagraph commencing with such month as the Secretary and the State agree upon, but only if (I) the Secretary has not found, under subsection (b)(1), that the State agency has substantially failed to make determinations under this subparagraph in accordance with the applicable provisions of this section or rules issued thereunder, and (II) the State has not notified the Secretary, under subsection (b)(2), that it does not wish to make determinations under this subparagraph. If the Secretary once makes the finding described in clause (I) of the preceding sentence, or the State gives the notice referred to in clause (II) of such sentence, the Secretary may thereafter determine whether (and, if so, beginning with which month and under what conditions) the State may again make determinations under this subparagraph.

"(ii) Any determination made by a State agency under clause (i) shall be made in the manner prescribed for determinations under subsection (a)(2) and regulations prescribed ~~thereunder, except that it shall be made after opportunity for an evidentiary hearing~~ *thereunder; except that it shall be made after opportunity for an evidentiary hearing which is reasonably accessible to the claimant, and which is held by an adjudicatory unit of the State agency other than the unit that made the determination (relating to the claimant's disability or period of disability) on which the decision being reconsidered was based.*

"(3) A decision by the Secretary on reconsideration under this subsection in the course of which a determination relating to disability or to a period of disability is required and which is in whole or in part unfavorable to the individual requesting the reconsideration shall contain a statement of the case, in understandable language, setting forth a discussion of the evidence, the Secretary's decision, and the reason or reasons upon which the decision is based.

"(4) The Secretary shall prescribe by regulation procedures for the reconsideration under this subsection of issues other than issues relating to disability or a period of disability.

"(5) No documentary evidence which is submitted on or after the date of a decision on reconsideration under this subsection relating to entitlement to benefits for periods preceding the date of such decision (hereafter in this section referred to as the 'relevant periods'), ~~and which could have been available before such date,~~ *where such decision was made after opportunity for an evidentiary hearing pursuant to paragraph (2)(B)(ii) or subsection (i) and where such evidence could have been available before the date of that decision,* shall be admitted or considered in connection with entitlement to such benefits for such periods, except as provided in subsection (e)(3). Nothing in the preceding sentence, subsection (e)(3), or section 202(j)(2), 216(i)(2)(G), or 223(b) shall be construed to permit, prohibit, or otherwise affect the admission or consideration, at or in connection with any proceeding in which a reconsideration decision relating to an individual's entitlement to benefits for particular relevant periods is involved, of evidence relating to such individual's entitlement to benefits for any other period.

"(6) Each individual who requests a reconsideration under paragraph (1) shall be informed, orally and in writing, before the reconsideration, of the preceding provisions of this subsection, and shall be advised that the individual may wish to retain an attorney or other representative to assist him during the reconsideration.

"(e)(1) Upon request by any individual described in subsection (d)(1) who makes a showing in writing that his or her rights may be prejudiced by a decision on reconsideration under this section, the Secretary shall give such individual and the other individuals described in subsection (d)(1) reasonable notice and opportunity for a hearing. Any such request with respect to such a decision must be filed within sixty days after notice of such decision is received by the individual making such request.

"(2) If a hearing under paragraph (1) is held, the Secretary shall, on the basis of the evidence considered in reaching the reconsideration decision and the testimony given at the hearing, and in accordance with the relevant provisions of this title, regulations of the Secretary, and any written guidelines which the Secretary may prescribe in carrying out the last sentence of section 205(a), render a decision on entitlement to benefits for the relevant periods, including in such decision a statement of the findings of fact, conclusions, and the reasons or bases therefor. The hearing decision may affirm, modify, or reverse the Secretary's findings of fact and the decison on reconsideration.

"(3)(A) In any case in which the individual making the request under paragraph (1) or any other individual described in subsection (d)(1) submits to the Secretary, on or after the date of the decision on reconsideration under subsection (d) and before the commencement of a hearing under this subsection, additional documentary evidence relating to disability or to a period of disability affecting entitlement to benefits for the relevant periods ~~which could have been submitted before the date of the decision on reconsideration,~~ *which is otherwise prevented by subsection (d)(5) from being admitted or considered in connection with such entitlement,* and the individual does not make the election under subparagraph (B)—

"(i) if the determinations made in the course of such decision on reconsideration include a determination relating to disability or to a period of disability which was made by a State agency under subsection (d)(2)(B), such additional evidence, together with the evidence considered in reaching the reconsideration decision, shall be remanded to the State agency, or

"(ii) if such determination relating to disability or to a period of disability was made by the Secretary in accordance with subsection (i), such additional evidence, together with the evidence considered in reaching the reconsideration decision, shall be reviewed by the Secretary.

"(B) An individual who submits additional evidence as described in subparagraph (A) may nevertheless elect that no remand or review occur under subparagraph (A) with respect to such evidence and that such additional evidence be disregarded for purposes of determining entitlement under this subsection. The Secretary shall notify such individual upon submitting such evidence of the provisions of this paragraph and of the election available under this subparagraph and provide such individual with a reasonable period of time within which to make such election before remanding or reviewing such evidence under subparagraph (A).

"(C) The State agency, on remand, or the Secretary, on review, shall consider the record, as supplemented by such additional evidence, in connection with benefits for the relevant periods and shall affirm, modify, or reverse the determination on reconsideration relating to disability or to a period of disability. The Secretary shall inform such applicant or other individual of the decision on further reconsideration based on determinations made on such remand or in such review and of the right to request a hearing thereon under this subsection.

"(4) The Secretary shall prescribe by regulation a period of time after hearing decisions under this section during which the Secretary, on his own motion or on the request of the individual requesting the hearing, may undertake a review of such decision. If such decision is not so reviewed, such decision shall be considered the final decision of the Secretary at the end of such period. If such decision is so reviewed, at the end of any such review the Secretary shall affirm, modify, or reverse the decision and such decision as so affirmed, modified, or reversed shall be considered the final decision of the Secretary. Any such review shall be governed by the requirements of this subsection.".

(2) Section 221 of such Act is further amended—

(A) in subsection (b)(1), by inserting "under subsection (a)(1) or subsection (d)" after "disability ~~determination~~ *determinations*" the first place it appears, and by inserting before the period the following: "or the disability determinations referred to in subsection (d)(2) (as the case may be)";

(B) in subsection (b)(2), by inserting "or under subsection (d)(2) (as the case may be)" after "subsection (a)(1)" the first place it appears, and by inserting before the period in the last sentence the following: "or the disability ~~redeterminations~~ *determinations* referred to in subsection (d)(2) (as the case may be)";

(C) in subsection (b)(3)(A), by inserting "under subsection (a) or subsection (d)" after "function", and by inserting "under subsection (a) or subsection (d) (as the case may be)" after "process";

(D) in subsection (b)(3)(B), by inserting "under subsection (a) or subsection (d)" after "function", and by inserting "under subsection (a) or subsection (d) (as the case may be)" after "process";

(E) in subsection (f) (as redesignated by paragraph (1)), by inserting "(1)" before "Any", by striking out "subsection (a), (b), (c), or (g)" and inserting in lieu thereof "subsection (b)", and by adding at the end thereof the following new paragraph:

"(2) Any individual who requests a hearing under subsection (e) and who is dissatisfied with the Secretary's final decision after such hearing shall be entitled to judicial review of such decision as is provided in section 205(g).";

(F) in subsection (g) (as redesignated by paragraph (1)), by striking out "under this section" and inserting in lieu thereof "or subsection (d)(2)", by inserting "or under subsection (d)(2), as the case may be" after "under subsection (a)(1)" the second place it appears, and by striking out "subsection (f)" and inserting in lieu thereof "subsection (h)";

(G) in subsection (i) (as redesignated by paragraph (1)), by inserting "or subsection (d)(2)" after "subsection (a)(1)", by inserting "under subsection (a)(1) or subsection (d)(2)" after "disability determinations" the second place it appears, by inserting after "guidelines," the following: "in the case of disability determinations under subsection (d)(2) to which subparagraph (B) thereof does not apply,", by inserting "under subsection (a) or subsection (d)" after "disability determinations" the third place it appears, by inserting "or the determinations referred to in subsection (d) (as the case may be)" after "in subsection (a)", and by adding at the end thereof the following new sentence: "In the case of a reconsideration by the Secretary of a decision to terminate benefits, any disability determination made by the Secretary under this subsection in the course of such reconsideration shall be made after opportunity for ~~an evidentiary hearing~~ *an evidentiary hearing which is reasonably accessible to the claimant (and which is not held by the same person or persons who made the determination, relating to the claimant's disability or period of disability, on which the decision being reconsidered was based)*."; and

(H) in subsection (j) (as redesignated by paragraph (1)), by adding at the end thereof the following new sentence: "An individual who makes a showing in writing that his or her rights may be prejudiced by a determination under this subsection with respect to continuing eligibility shall be entitled to a reconsideration and a hearing to the same extent and in the same manner as provided under subsections (d) and (e).".

~~(c)(1)~~ *(d)* The third sentence of section 1631(c)(1) of such Act is amended by striking out "within sixty days after notice of such determination is received" and inserting in lieu thereof "within 180 days after notice of such determination is received where the matter in disagreement involves blindness (within the meaning of section 1614(a)(2)) or disability (within the meaning of section 1614(a)(3)) or within 60 days after such notice is received in any other case".

~~(2) Section 1631(c)(3) of such Act is amended by inserting "(but without regard to the amendments made by section 5(c) of the Disability Amendments of 1982)" after "judicial review as provided in section 205(g)".~~

~~(f)(1)~~ *(e)(1)* Except as provided in ~~paragraph (2)~~ *paragraphs (2) and (3),* the amendments made by this section shall apply with respect to requests for reconsideration of decisions by the Secretary of Health and Human Services filed after the date of the enactment of this ~~Act, except that section 221(d)(2)(B) of the Social Security Act (as amended by subsection (d) of this section) shall apply with respect to such requests filed on or after January 1, 1984~~ *Act.*

(2) The amendments made by subsection (a) shall apply with respect to applications for benefits filed after the date of the enactment of this Act.

(3) Section 221(d)(2)(B) of the Social Security Act, as amended by subsection (c) of this section, shall apply only with respect to requests (for reconsideration of decisions by the Secretary) filed—

(A) on or after January 1, 1984, or

(B) with respect to determinations (relating to disability or to periods of disability) to be made by a State agency in any State which notifies the Secretary in writing that it wishes to make determinations under such section 221(d)(2)(B) prior to January 1, 1984, on or after the first day of such month (after the month in which this Act is enacted and prior to January 1984) as may be specified in such notice.

For purposes of such section 221(d)(2)(B), each State shall initially notify the Secretary in writing that it wishes to make determinations under such section (specifying the month with which it wishes to commence making such determinations), or shall notify the Secretary in writing that it does not wish to make such determinations, no later than January 1, 1983; and any State which has not so notified the Secretary by January 1, 1983, shall be deemed for all the purposes of section 221 of the Social Security Act to have *notified the Secretary in writing (as of that date) that it does not wish to make such determinations.*

~~(g) Notwithstanding any other provison of law, the Office of Personnel Management shall treat relevant experience of attorneys employed by the Social Security Administration in the process of adjudicating social security claims (without regard to the grade or level at which the employment involved is performed) as qualifying experience for appointment by the Secretary of Health and Human Services to the position of administrative law judge under section 3105 of title 5, United States Code, pursuant to section 205(b)(7)(B) of the Social Security Act (as added by this section).~~

OWN MOTION REVIEW; REVIEW OF STATE AGENCY DETERMINATIONS

SEC. 6. (a) Section 304(g) of the Social Security Disability Amendments of 1980 is amended by inserting "(1)" after "(g)", and by adding at the end thereof the following new paragraph:

"(2) In implementing and carrying out the program referred to in paragraph (1), the Secretary shall review—

"(A) at least 15 percent of all decisions, rendered by administrative law judges in the fiscal year 1982 as a result of hearings under section 221(e) of the Social Security Act, that individuals are or continue to be under disabilities (as defined in section 216(i) or 223(d) of such Act); and

"(B) at least 25 percent of all such decisions so rendered in any fiscal year after the fiscal year 1982 and before the fiscal year 1988.".

(b)(1) Section 221(c) of the Social Security Act is amended by striking out paragraphs (2) and (3) and inserting in lieu thereof the following:

"(2) The Secretary shall review at least 10 percent of all determinations, made by State agencies under this section in any fiscal year after the fiscal year 1982 and before the fiscal year 1988, that individuals are or are not under disabilities (as defined in section 216(i) or 223(d)), with at least one-sixth of all of the determinations so reviewed being determinations that the individuals involved are not under disabilities (as so defined). Any review by the Secretary of a State agency determination under this paragraph shall be made before any action is taken to implement such determination.".

(2)(A) Section 221(c)(1) of such Act is amended by striking out "paragraphs (2) and (3)" and inserting in lieu thereof "paragraph (2)".

(B) Effective October 1, 1987, section 221(c)(1) of such Act (as amended by subparagraph (A) of this paragraph) is further amended by striking out "or as required under paragraph (2)".

(3) Except as provided in paragraph (2)(B), the amendments made by this subsection shall become effective October 1, 1982.

STANDARDS FOR DISABILITY DETERMINATIONS

SEC. 7. Section 205(a) of the Social Security Act is amended by adding at the end thereof the following new sentence: "The Secretary shall assure that uniform standards are applied at all levels of adjudication in making determinations of whether individuals are under disabilities as defined in section 216(i) or 223(d).".

EVALUATION OF PAIN

SEC. 8. (a) Section 223(d)(5) of the Social Security Act is amended by inserting after the first sentence the following new sentence: "An individual's statement as to pain or other symptoms shall not alone be conclusive evidence of disability as defined in this section; there must be medical signs and findings, established by medically acceptable clinical or laboratory diagnostic techniques, which show the existence of a medical condition that could reasonably be expected to produce the pain or other symptoms alleged and which, when considered with all evidence required to be furnished under this paragraph (including statements of the individual as to the intensity and persistence of such pain or other symptoms which may reasonably be accepted as consistent with the medical signs and findings), would lead to a conclusion that the individual is under a disability.".

(b) The amendment made by subsection (a) shall apply with respect to determinations of disability made on or after the date of the enactment of this Act.

SUBSTANTIAL GAINFUL ACTIVITY AND TRIAL WORK

SEC. 9. (a) The second sentence of section 223(d)(4) of the Social Security Act is amended by inserting before the period at the end thereof the following: "; and no other individual shall be regarded as having demonstrated an ability to engage in substantial gainful activity on the basis of earnings that do not exceed (i) the amount which was sufficient, under the regulations of the Secretary then in effect, to cause an individual to be treated as having demonstrated such an ability in the month in which the Disability Amendments of 1982 were enacted, or (ii) if one or more increases in exempt amounts under section 203(f)(8) have occurred pursuant to subparagraph (B) thereof during the period beginning with the month after the month specified in clause (i) and ending with the month in which the particular earnings involved are derived, the amount to which the amount specified in clause (i) would have increased under such section 203(f)(8) during such period if (in the month specified in clause (i)) it had been an exempt amount applicable to individuals other than those described in subparagraph (D) of such section ~~203(f)(8).~~ *203(f)(8)".*

(b) The second sentence of section 222(c)(2) of such Act is amended to read as follows: "For purposes of this subsection the term 'services' means activity which is determined by the Secretary to be of a type normally performed for remuneration or gain, and which is performed (by the particular individual involved) in any month for remuneration or gain at least equal to (A) the amount of remuneration or gain which was sufficient, under the regulations of the Secretary then in effect, to cause the activity to be treated as constituting 'services' for such purposes in the month in which the Disability Amendments of 1982 were enacted, or (B) if one or more increases in exempt amounts under section 203(f)(8) have occurred pursuant to subparagraph (B) thereof during the period beginning with the month after the month specified in clause (A) of this sentence and ending with the month in which the particular activity involved is performed, the amount to which the amount specified in clause (A) of this sentence would have increased under such section 203(f)(8) during such period if (in the month specified in clause (A)) it had been an exempt amount applicable to individuals other than those described in subparagraph (D) of such section 203(f)(8).".

(c)(1) Section 1614(a)(3)(D) of such Act is amended by inserting after the first sentence the following new sentence: "No individual who is an aged, blind, or disabled individual solely by reason of disability (as determined under this paragraph (shall be regarded as having demonstrated an ability to engage in substantial gainful activity on the basis of earnings that do not exceed (i) the amount which was sufficient, under the regulations of the Secretary then in effect, to cause an individual to be treated as having demonstrated such an ability in the month in which the Disability Amendments of 1982 were enacted, or (ii) if one or more increases in exempt amounts under section 203(f)(8) have occurred pursuant to subparagraph (B) thereof during the period beginning with the month after the month specified in clause (i) and ending with the month in which the particular earnings involved are derived, the amount to which the amount specified in clause (i) would have increased under such section 203(f)(8) during such period if (in the month specified in clause (i)) it had been an exempt amount applicable to individuals other than those described in subparagraph (D) of such section 203(f)(8).".

(2) The second sentence of section 1614(a)(4)(A) of such Act is amended to read as follows: "As used in this paragraph with respect to any individual who is an aged, blind, or disabled individual solely by reason of disability (as determined under paragraph (3)), the term 'services' means activi-

ty which is determined by the Secretary to be of a type normally performed for remuneration or gain, and which is performed (by the particular individual involved) in any month for remuneration or gain at least equal to (i) the amount of remuneration or gain which was sufficient, under the regulations of the Secretary then in effect, to cause the activity to be treated as constituting 'services' for purposes of this paragraph in the month in which the Disability Amendments of 1982 were enacted, or (ii) if one or more increases in exempt amounts under section 203(f)(8) have occurred pursuant to subparagraph (B) thereof during the period beginning with the month after the month specified in clause (i) of this sentence and ending with the month in which the particular activity involved is performed, the amount to which the amount specified in clause (i) of this sentence would have increased under such section 203(f)(8) during such period if (in the month specified in clause (i)) it had been an exempt amount applicable to individuals other than those described in subparagraph (D) of such section 203(f)(8).".

(d) The amendments made by this section shall apply with respect to months after December 1982.

PROHIBITION AGAINST INTERIM PAYMENTS

SEC. 10. Section 205 of the Social Security Act is amended by adding at the end thereof the following new subsection:

"Prohibition Against Interim Payments

"(r) No amount shall be paid to any individual applying for benefits under this title until a final determination of his or her entitlement to such benefits has been made.".

AMENDMENTS RELATING TO REDUCTION IN DISABILITY INSURANCE BENEFITS ON ACCOUNT OF OTHER RELATED PAYMENTS

SEC. 11. (a) Section 2208(b) of the Omnibus Budget Reconciliation Act of 1981 is amended by inserting before the period at the end thereof the following: "; except that the amendment made by subsection (a)(2) shall be effective in the case of an individual who attains age 62 after the month in which the Disability Amendments of 1982 are enacted even though he became disabled within the meaning of section 223(d) of the Social Security Act in or prior to such sixth month".

(b) Section 202(q)(7)(F) of the Social Security Act is amended to read as follows:

"(F) in the case of old-age insurance benefits, any month for which such individual (i) received a disability insurance benefit, or (ii)(I) would have received a disability insurance benefit but for the application of section 223(f) or section 224 and (II) did not receive an old-age insurance benefit.".

(c) Section 224(a)(2) of such Act (as amended by section 2208 of the Omnibus Budget Reconciliation Act of 1981) is further amended to read as follows:

"(2) such individual is entitled for such month on account of his total or partial disability (whether or not permanent)—

"(A) to periodic benefits under a workmen's compensation law or plan of the United States or a State, or

"(B) to periodic benefits under any other law or plan of the United States, a State, a political subdivision (as that term is used in section 218(b)(2)), or an instrumentality of two or more States (as that term is used in section 218(k)), other than benefits payable under title 38, United States Code, benefits payable under a program of assistance which is based on need, benefits based on service all or substantially all of which was included under an agreement entered into by a State and the Secretary under section 218, and benefits under a law or plan of the United States based on service all or substantially all of which is employment as defined in section 210,".

(d) Section 224(a) of such Act is further amended—

(1) by striking out clause (A) in the sentence immediately following clause (8);

(2) by redesignating clauses (B) and (C) in such sentence as clauses (A) and (B), respectively;

(3) by striking out "(computed without regard to the limitations specified in sections 209(a) and 211(b)(1))" each place it appears in such sentence; and

(4) by adding at the end thereof the following new sentence: "For purposes of the preceding sentence, the total of an individual's wages and self-employment income for any year or other period shall be computed without regard to the limitations specified in sections 209(a) and 211(b)(1); and the total of an individual's wages for the period consisting of the calendar year in which he became disabled (as defined in section 223(d)) and the five years preceding that year shall also include the amount of any additional earnings which would have been credited to such individual under this title as wages for that period (computed without regard to such limitations) if none of the exclusions contained in paragraphs (5), (6), (7), and (8)(B) of section 210(a) had been in effect, to the extent that such individual substantiates his receipt of such amount (and the performance of the services involved) to the satisfaction of the Secretary.".

(e) The amendments made by this section shall be effective in the same manner and as of the same time as they would if they had been included in section 2208(a) of the Omnibus Budget Reconciliation Act of 1981; except that the amendment made by subsection (b) shall be effective only with respect to individuals who attain age 65 after the date of the enactment of this Act, ~~and the amendments made by subsection (d)~~ *the amendments made by paragraphs (1) and (2) of subsection (d)* shall be effective only with respect to individuals who first become entitled to benefits under section 223 of the Social Security Act for months beginning after the month in which this Act is ~~enacted~~ *enacted, and the amendments made by paragraphs (3) and (4) of subsection (d) shall be effective with respect to months beginning after the month in which this Act is enacted.*

PAYMENT OF COSTS OF REHABILITATION SERVICES FROM TRUST FUNDS; EXPERIMENTS AND DEMONSTRATION PROJECTS

SEC. 12. (a)(1) So much of section 222(d) of the Social Security Act as precedes paragraph (4) thereof is amended to read as follows:

"Payment of Costs of Rehabilitation Services From Trust Funds

"(d)(1)(A) For purposes of making vocational rehabilitation services more readily available to disabled individuals who are—

"(i) entitled to disability insurance benefits under section 223,

"(ii) entitled to child's insurance benefits under section 202(d) after having attained age 18 (and are under a disability),

"(iii) entitled to widow's insurance benefits under section 202(e) before attaining age 60, or

"(iv) entitled to widower's insurance benefits under section 202(f) before attaining age 60,

to the end that savings will accrue to the Trust Funds as a result of rehabilitating such individuals into substantial gainful activity, there are authorized to be transferred from the Federal Old-Age and Survivors Insurance Trust Fund and the Federal Disability Insurance Trust Fund each fiscal year such sums as may be necessary to enable the Secretary to pay the State (under a State plan for vocational rehabilitation services approved under title I of the Rehabilitation Act of 1973 (29 U.S.C. 701 et seq.)), or another public or private agency, organization, institution, or individual (under an agreement or contract entered into under subparagraph (D) of this paragraph), the reasonable and necessary costs of vocational rehabilitation services furnished such individuals (including services during their waiting periods) which meet the requirements of subparagraph (B). The determination that the vocational rehabilitation services meet the requirements of subparagraph (B) and the determination of the amount of costs to be paid under this paragraph shall be made by the Commissioner of Social Security in accordance with criteria formulated by him.

"(B) Vocational rehabilitation services furnished a disabled individual described in subparagraph (A) meet the requirements of this subparagraph—

"(i) to the extent such services consist of evaluation services as determined by the Commissioner of Social Security,

"(ii) if such services result in—

"(I) his performance of substantial gainful activity which lasts for a continuous period of nine months, or

"(II) his recovery from his disabling physical or mental impairment, or

"(iii) if such individual refuses without good cause to continue to accept vocational rehabilitation services or fails to cooperate in such a manner as to preclude such individual's successful rehabilitation.

"(C) Payments under this paragraph shall be made in advance (or, at the election of the recipient, by way of reimbursement), with necessary adjustments for overpayments and underpayments.

"(D) The Commissioner of Social Security may provide vocational rehabilitation services in States under regulations prescribed by the Secretary or by agreement, or contract, with other public or private agencies, organizations, institutions, or individuals. There are authorized to be transferred from the Federal Old-Age and Survivors Insurance Trust Fund and the Federal Disability Insurance Trust Fund such sums as are necessary for the payment of the reasonable and necessary costs of such services. The provision of such services, and the payment of costs for such services, shall be subject to the same requirements as otherwise apply under the preceding provisions of this paragraph.

"(E) The Commissioner of Social Security shall require each State and each public or private agency, organization, institution, or individual receiving payments under this paragraph to make such periodic reports to him concerning the operation of its program furnishing vocational rehabilitation services as are necessary to satisfy him that the amounts paid to such State, agency, organization, institution, or individual are used exclusively for furnishing such services in accordance with this paragraph.

"(2)(A) For purposes of making vocational evaluation and job placement services more readily available to individuals who were disabled individuals described in paragraph (1)(A) but whose entitlement to the benefits described in paragraph (1)(A) was terminated by reason of recovery from the disabling physical or mental impairment on which their disability was based or by reason of a finding that such impairment has not existed, there shall be transferred from the Federal Old-Age and Survivors Insurance Trust Fund and the Federal Disability Insurance Trust Fund not to exceed $15,000,000 for each of the fiscal years beginning on October 1, 1982, and October 1, 1983, respectively, to enable the Commissioner of the Rehabilitation Services Administration to pay to the State the costs of the reasonable and necessary costs of such services furnished such individuals by State agencies under a State plan for vocational rehabilitation services approved under title I of the Rehabilitation Act of 1973. The amount paid to each State for each year shall not exceed the amount which bears the same ratio to the total amount paid to States for such year under this paragraph as the ratio which the number of such entitlement terminations in such State in the preceding year bears to the total number of such entitlement terminations in the United States in such preceding year. Amounts remaining unpaid under this paragraph at the end of a fiscal year shall revert to the Trust Funds. The determination of the amount of costs to be paid under this paragraph shall be made by the Commissioner of the Rehabilitation Services Administration in accordance with criteria formulated by him.

"(B) Payments under this paragraph shall be made in advance (or, at the election of the recipient, by way of reimbursement), with necessary adjustments for overpayments and underpayments.

"(C) The Commissioner of the Rehabilitation Services Administration shall require each State agency receiving payments under this paragraph to make such periodic reports to him concerning the operation of its program furnishing vocational rehabilitation services as are necessary to satisfy him that amounts paid to such State, agency, organization, institution, or individual are used exclusively for furnishing such services in accordance with this paragraph.".

~~(2)(A)~~ *(2)* Section 222(d) of such Act is further amended by redesignating paragraphs (4) and (5) as paragraphs (3) and (4), respectively.

~~(B) Section 1615(d) of such Act is amended by striking out "section 222(d)(1)" and inserting in lieu thereof "section 222(d)(1)(A)"~~.

(3) Section 222(a) of such Act is amended—

(A) by striking out "and";

(B) by inserting before "shall" the following: "and individuals whose entitlement to such benefits is terminated by reason of recovery from the disabling physical or mental impairment on which their disability was based or by reason of a finding that such impairment has not existed (or is no longer disabling)"; and

(C) by inserting after "the State agency or agencies administering or supervising the administration of the State plan approved under the Vocational Rehabilitation Act" the following: ", or to other appropriate public or private agencies, organizations, institutions, or individuals,".

(b)(1)(A) Section 225(b) of such Act is repealed.

(B) Section 225(a) of such Act is amended—

(i) by striking out "(a)" after "SEC. 225."; and

(ii) by striking out "this subsection" each place it appears and inserting in lieu thereof "this section".

(C) Notwithstanding the preceding provisions of this paragraph, any individual who, immediately before the date of the enactment of this Act, was entitled to benefits based on disability referred to in section 225(b) of the Social Security Act (as in effect before its repeal by this subsection) by reason of participation in an approved vocational rehabilitation program referred to in such section shall continue to be so entitled in accordance with such section until the expiration of such program as if this paragraph had not been enacted.

(2)(A) Section 1615(d) of such Act is amended to read as follows:

"(d)(1) The Secretary is authorized to pay the State agency administering or supervising the administration of a State plan for vocational rehabilitation services approved under title I of the Rehabilitation Act of 1973 for the costs incurred under such plan in the provision of vocational rehabilitation services which meet the requirements of paragraph (2) to individuals who are referred for such services pursuant to subsection (a). The determination that services meet the requirements of paragraph (2), and the determination of the amount of the costs to be paid under this paragraph, shall be made by the Commissioner of Social Security in accordance with criteria determined by him in the same manner as under section 222(d)(1)(A).

"(2) Vocational rehabilitation services provided to an individual described in subsection (a) meets the requirements of this paragraph—

"(A) to the extent such services consist of evaluation services as determined by the Commissioner of Social Security,

"(B) if such services result in—

"(i) such individual's performance of substantial gainful activity which lasts for a continuous period of nine months, or

"(ii) such individual's recovery from his disabling physical or mental impairment, or

"(C) if such individual refuses without good cause to continue to accept vocational rehabilitation services or fails to cooperate in such a manner as to preclude such individual's successful rehabilitation.

"(3) Payments under this subsection shall be made in advance (or, at the election of the State agency involved, by way of reimbursement), with necessary adjustments for overpayments and underpayments.".

(B) Section 1615 of such Act is further amended by adding at the end thereof the following new subsection:

"(f) Notwithstanding any other provision of this section, the Secretary, instead of referring individuals age 16 or over to a designated State agency for vocational rehabilitation services as otherwise required by subsection (a), may provide such services to those individuals (in such cases as he may determine) by agreement or contract with other public or private agencies, organizations, institutions, or individuals. To the extent appropriate and feasible—

"(1) vocational rehabilitation services under the preceding sentence shall be provided in the same manner, and in accordance with the same requirements and criteria, as in the case of vocational rehabilitation services provided by agreement or contract under section 222(d)(1); and

"(2) all of the preceding provisions of this section which relate to services for individuals age 16 or over who are referred to a State agency under subsection (a) shall apply with respect to services provided to individuals age 16 or over by agreement or contract under the preceding sentence, in the same way that they apply with respect to services provided pursuant to such a referral, as though the agency, organization, institution, or individual involved were the designated State agency and such individuals had been referred to it under subsection (a).".

(c)(1) Section 505(a)(1) of the Social Security Disability Amendments of 1980 (Public Law 96-265; 94 Stat. 473) is amended—

(A) by striking out "(A)" and "(B)" and inserting in lieu thereof "(i)" and "(ii)", respectively;

(B) by inserting "(A)" before "the relative advantages";

(C) by inserting "and" after "administered,"; and

(D) by striking out "rehabilitation, and greater use of employers and others to develop, perform, and otherwise stimulate new forms of rehabilitation)," and inserting in lieu thereof the following: "rehabilitation); and (B) how best to use organizations organized for profit and those not so organized in providing vocational rehabilitation services to disabled beneficiaries;".

(2) Section 505(a)(2) of such Amendments is amended by adding at the end thereof the following new sentence: "Not later than 18 months after the date of the enactment of the Disability Amendments of 1982, the Secretary shall develop and commence at least 10 experiments or projects referred to in clause (B) of paragraph (1), with one or more of such experiments or projects commencing in each of at least 5 States.".

(3) Section 505(a)(4) of such Amendments is amended—

(A) by inserting "(A)" after "(4)"; and

(B) by adding at the end thereof the following new subparagraph:

"(B) The Secretary shall submit to the Congress no later than the end of the 18-month period referred to in the last sentence of paragraph (2) a report on the experiments and demonstration projects described in clause (B) of paragraph (1) which are commenced under this subsection together with any related data and materials which he may consider appropriate.".

(d)(1) The amendments made by subsection (a) shall take effect on the date of the enactment of this Act, and section 222(d)(1) of the Social Security Act (as amended by such subsection) shall apply (from and after such date) with respect to services rendered on or after October 1, 1981; except that in the case of services of the type described in clause (i) of section 222(d)(1)(B) of such Act (as amended by such subsection) such amendments shall apply only with respect to services rendered on or after October 1, 1982.

(2) The amendments made by subsections (b) and (c) shall take effect on the date of the enactment of this Act; except that the amendment made by subsection (b)(2) shall apply only with respect to services provided on or after October 1, 1982.

Senator CHAFEE. Now, on page 4 you make a very substantial claim in the middle of the page. You say the social security funds are running a deficit of $17,000 a minute. I assume you are taking the overall social security, not just this.

Mr. SIMMONS. Yes, sir. That's all three trust funds combined.

Senator CHAFEE. And "44 percent of that can be attributed to the payment of disability benefits to those who are not disabled." That's a very strong claim. What do you have to back that up?

Mr. SIMMONS. That is a function of our finding that about 28 percent of those on the roles are not eligible and that the loss rate for that is $4 billion a year. That is a mathematical function of that.

Senator CHAFEE. I see.

Senator HEINZ. Would the Senator yield for a question?

Senator CHAFEE. Well, I think we have a host of people here, but if you want to make it quick.

Senator HEINZ. Well, I just want to reinforce your point. It is my understanding that the disability fund is the one that is making money.

Mr. SIMMONS. Well, the argument that the disability fund is actuarily in better shape than the others really is irrelevant to the whole system.

Senator HEINZ. Well, is the outflow greater or lesser than the inflow?

Mr. SIMMONS. The disability fund is one of the two that under current rates are making a profit, sc to speak.

Senator HEINZ. Thank you.

Senator CHAFEE. Thank you, Mr. Chairman.

Senator ARMSTRONG. Thank you, Senator Chafee.

Senator Durenberger?

Senator DURENBERGER. Thank you very much.

I don't want to start out quarrelsome, but I don't think it is irrelevant that one fund is in better shape or lesser shape than the other. Last year we got forced into the position through deficit politics of using both the disability fund and the medicare fund to fund the retirement of a lot of millionaires in this country through the Social Security system. I think there are some of us who found it very difficult to deal either with the disability problem here and the so-called change in philosophy of the program that you testified to earlier or the cuts that were made in this committee and on the floor of the Senate in medicare, many of which dealt with this $17,000-a-minute issue.

But let me go one step beyond where Senator Heinz was with his question into an area that I know that he is very sensitive about. Clearly in your testimony you indicated there is a change in the philosophy of the program. Is that correct?

Mr. SIMMONS. Well, I think there have been many changes in the philosophy of the program that have come and gone. In 1970, for example, as a percentage of the total caseload on the disability rolls, we were doing more CDI's than we are doing now. And then during the mid-1970's CDI's kind of fell off, because the workloads went up so much and the influx of people coming into the system was so great. Then in 1980 the Congress looked with alarm at that and said, "Well, we'd better do something about it." And this was through bipartisan action, and it is a bipartisan concern; the change in philosophy being that, "instead of just looking at, say, the 150,000 cases that you always looked at, you will look at all of them in a period of 3 years." That is a change in philosophy.

Senator Durenberger. Let me take that one step beyond the medical determination and deal with: Does impairment prevent him from doing his past relevant work, and can he perform any other jobs which exist in significant numbers in the national economy?

Clearly things have changed in this country in the last few years as well, and I wonder if you wouldn't just take us through the process in CDI of determining how you come to the conclusion that in a particular case, having made a medical determination, that impairment does not prevent an individual from doing his relevant work or that there are other jobs which exist in significant numbers in the national economy?

Mr. Simmons. I would ask Ms. Greenberg to explain that, and I would just say conceptually that that is the legal definition—"Can you do work in the economy?"—and the question is, are there jobs available. She will explain how we arrive at listings of jobs, et cetera, but the economy naturally changes, too, and as we become more and more of a service economy with more than half of the jobs now in the service economy, that's a societal change, really, that has occurred to us. It is no longer only the steel factory job; it could be the parking lot attendant or the fast food attendant, or something like that.

Would you run through that list, please?

Ms. Greenberg. Senator, the same basic policy applies in continuing disability as applies in initial disability decisions. Past relevant work, which is an adjudicative step once you decide somebody has a severe impairment, is gaged from the time you are making the decision. So we look at work that that person has done, going back in time from today, when we are looking at his case.

When we get back in time we decide that work is no longer relevant. If he has been on the rolls 15 years, there is not going to be relevant work. So we will look then at the combination of what we call "the vocational factors"—age, education, and work experience.

We have in our regulations, again the same for initial decisions as for continuing disability investigations, a set of guidelines that direct our people to evaluate the impact of age, the impact of education and its recency, and again the impact of work.

For example, you could have somebody who has been on the rolls for some time and not worked but participated in rehabilitation programs and acquired quite a bit of vocational training. That changes his vocational outlook from the time that he was originally allowed. And you have to take that into consideration.

Senator Durenberger. Well, I guess one of the things that bothers me the most is when you get into people over 50 or 55 years of age, and here is where Senator Heinz has a great deal of sensitivity, from the Committee on Aging.

The last phone call that I had on one of these things was at the end of last week. Somebody who had had a multiple bypass about 7 years ago just went through CDI in Minnesota and came out with a clean bill of health and passed all the rest of these work tests, so that at age 59 he was sent back to work in a nonexistent job in an elevator in a little town called Belgrade, Minn. I don't know whether that was because they thought there was a job in Belgrade—which there isn't—or because someplace in this country somebody is employing 59-year old grain loaders in significant numbers in country elevators. I rather doubt it. Maybe you can give me the answer to that.

Ms. GREENBERG. The policy, though, that you are describing is reflected from the exact words in the law. The words in the law talk about making disability decisions regardless of whether somebody would be hired, regardless of whether there is a job in his town, and so on. Those criteria are in the law itself.

Senator DURENBERGER. Do you think that's something that ought to be changed in the law?

Mr. SIMMONS. That would be a philosophical decision that would have to be made by the Congress over time, whether or not this program should be what it is—a last resort for somebody who is unable to work at all, or whether you want to turn this into a program that refers people to specific jobs and keeps paying them benefits when they are not hired. Then it is no longer a disability insurance program, it's a welfare program. And that is not what is envisioned in the Social Security Act. That's why we have unemployment programs, worker's compensation programs, and the general assistance programs at the State level, to handle people who have a financial need and, for whatever reason, can't work but aren't necessarily disabled.

The tragedy of unemployment and the tragedy of age discrimination in employment is something that is not addressed in Social Security Administration programs and is something that we don't think should be addressed in them; but that is a congressional decision, not ours.

Senator ARMSTRONG. Senator Grassley?

Senator GRASSLEY. I think one of our problems is people's perception or lack of understanding regarding disability insurance. I would like to know what steps could be taken—and what programs are presently in place—to better inform individuals of the true nature of disability insurance, and also of their rights in the appeal process.

Mr. SIMMONS. Well, in the past several years we certainly have taken more pains than were taken say in the mid-1970's, when the surge in the caseload occurred, to inform people as they come into the system what this is. We are now of course telling them that under the law, unless they qualify as totally and permanently disabled, they will be reviewed every three years under the new amendments. And we are giving serious consideration to moving the face to face concept up to the front end of the system. We now see many of these people face to face when they first come in on CDI, when they first get a letter from the State agency; but we are considering having the offices actually talk to all of these people and walk them through the process. We do that now with very many mental cases who may have a problem in understanding things. We would like to extend the concept, if it is feasible, to the entire population, and we're working very hard on that. This would move the first face to face discussion with the decisionmaker right up to the very front of the CDI process. We think that would do a lot to allay a lot of people's fears, to show them how important it is to bring all available evidence that they have in their case to the first level and then cooperate between that level and a face to face reconsideration process, which is in the Pickle bill and which we are supporting very strongly.

We think that there would be a lot less misunderstanding and a lot fewer of the kinds of horror stories that we keep seeing where somebody who is obviously disabled is taken off the rolls because no one has seen that person until he or she gets all the way to the ALJ level. We think that that is a bad system. It is an anomaly that has been built up over time, and it is something that should be fixed. But one of the things that needs to be fixed to go with that is to enable us to pay benefits through the reconsideration process and then lengthen that appeal process out long enough so that people are encouraged to bring in more evidence and develop all available evidence.

Now the tendency in many cases is for a person's lawyer or representative to bypass the first two stages and say, "Don't worry about it; we'll wait until we get to the judge, and then we will bring in the evidence." We think the evidence should be brought in up front, and if we could get more people to focus on that reconsideration process as a true evidentiary hearing with a good decision expected out of it, a fair decision, then we think there would be a lot less trouble and a lot less backlog on the ALJ's and a lot neater system, a lot fewer horror stories.

Senator GRASSLEY. Is it too early to determine whether this procedure is serving the good purpose you hoped it would?

Mr. SIMMONS. The face to face?

Senator GRASSLEY. Yes.

Mr. SIMMONS. We have found, in those cases where we do do it, that it has made a difference, and we think that the concept is valid. It is now a matter of figuring out how to do it and when we can do it administratively and within our budget.

Senator GRASSLEY. In my State of Iowa the Director of Vocational Rehabilitation indicated that State agencies are hampered by the inconsistency in the amount of review cases sent to the States by the Social Security Administration on a month-by-month basis. Is there any way the Social Security Administration can smooth out the number of cases sent to the States to provide for a more consistent and manageable workload by the States?

Mr. SIMMONS. Well, as I announced earlier, we are imposing a selective moratorium this month and next in order to help certain States, and there are quite a few, catch up with the backlog. We have provided States with about 30 percent more in resources this year in order to staff up to meet the backlog, and we're reducing the number of periodic reviews that will be sent out in the coming fiscal year by about 165,000 precisely for that reason—to help smooth out the workload and to help make sure that they are getting ample time and ample attention at the State agency level, and then of course in our own appeals level.

Senator GRASSLEY. Thank you, Mr. Chairman.

Senator ARMSTRONG. Thank you, Senator Grassley.

Senator Mitchell?

I note that we have 100 percent of the Maine delegation present here today.

Senator MITCHELL. Not only that, Mr. Chairman, but I believe Mr. Simmons is from Maine.

Mr. SIMMONS. I am from Maine, and I have parents up there who are voters. [Laughter.]

Senator MITCHELL. Are they?

Senator ARMSTRONG. We appreciate you letting us come to this Maine caucus.

Mr. SIMMONS. You may want to inquire how they vote.

Senator MITCHELL. No, I'm afraid I know the answer; so I don't think I will inquire. [Laughter.]

Senator MITCHELL. Mr. Simmons, I would like to ask you a few questions, following up on points that were touched on briefly by Senators Heinz and Durenberger regarding your statement on page 4 that "Social security trust funds are running at a deficit that mounts by $17,000 per minute," and attributing a portion of that to payment of DI benefits to people who are not disabled.

First, it is true, is it not, that the disability trust fund itself is now solvent?

Mr. SIMMONS. Yes, sir, it is solvent. When the tax rate was last adjusted for that fund it was thought that the disability incidence rate in the economy was going to be higher or continue on the track it was, but it is not. So that fund is relatively healthy. But it is a very small fund in relation to the other two.

But the reason that I mentioned before that it is irrelevant is that it all comes out of the same tax, off the same paychecks.

Senator MITCHELL. Right.

Mr. SIMMONS. And the solvency of the system, as you know, is at great issue, with the National Commission and the Congress going to have to look at this in the future. When we have a problem where the trust funds have been losing money over a period of time—8 straight years now—and you can show, with the GAO looking over your shoulder and with our own auditors looking at it, that perhaps 44 percent of the loss rate is going into one kind of a problem that could be corrected in the program, that's why I think it is relevant to point out that it is indeed 44 percent of our problem.

Senator MITCHELL. Right. And I do not agree with those who suggest that it is relevant, I merely wanted to point that out. And in fact the trustee's report earlier this year indicates that the disability fund will remain solvent through the period projected—that is through the year 2060—under any of the four alternative economic projections. Is that not correct?

Mr. SIMMONS. That is correct.

Senator MITCHELL. That is, the four economic projections ranged from the most optimistic to the least optimistic, or if you want, pessimistic; and no matter what the alternative is, the disability fund is projected to remain solvent, indeed there is a very, very substantial surplus.

Mr. SIMMONS. Well, that assumes that the Congress does not do what it has done many times over the past 47 years of the program, and that is to adjust the allocation of the tax rate to reflect which trust fund needs the money most.

Senator MITCHELL. Oh, certainly.

Mr. SIMMONS. And if you have one that gets actuarily too far out of balance in either way, you merge them financially or you transfer some of the tax rate, which the Congress did last year, of course, with the amendment to allow inter-fund borrowing. We are going to draw down some money; probably we will have to draw down some money from the disability trust fund as well as the hospital insurance trust fund in order to make payments.

Senator MITCHELL. Well, obviously it assumes that, and I don't think there is any disagreement on that.

Now, with respect to the $17,000-a-minute and your most recent statement that the fund—I think you said—showed a deficit over the last 8 years?

Mr. SIMMONS. Well, it is in the last 8 years that we have been spending more in the OASDI program than we have taken in, for 8 straight years.

Senator MITCHELL. I have before me a table dated August 4 from the Office of the Actuary which indicates that for the calendar year 1981 there was a net increase in funds of $3.1 billion.

Mr. SIMMONS. That is correct; however, those figures include the hospital insurance trust fund which ran a surplus last year. Also, early on in 1981 there was a little surge, and money came in; but then as the rest of the year went on the trend continued down.

Senator MITCHELL. So when you reach the maximum income subject to tax, they stop paying tax?

Mr. SIMMONS. Yes. And the economy was in a little better shape earlier on in the first months than over the year. But if you look at the trend line for the level of trust fund reserves since 1974, it goes right straight down like that.

In 1970 we had a 95-percent reserve in the three trust funds; in 1982 we are down to about 15 percent in the OASI fund, and maybe 22 percent in all three funds. And that is like 2 months benefits because you need 9 percent of the year's funds to pay a month's benefits.

Senator MITCHELL. Right.

Now, the $17,000 figure, based on your calculation, is obviously a reflection of the next figure in this table which shows an anticipated net decrease of $8.8 billion in 1982. My question is: Is your figure — which has been given a lot of publicity, as you know, Commissioner Svahn has used it several times on television and in other things — is that an actual calculation, or is that a projection based upon what you expect to happen through all of 1982?

Mr. SIMMONS. It is a calculation based on what is happening in 1982, and the actuaries took the figures and looked at the economy, the way we always do, and they just factored out how much money we will be down during the year. Then you divide that by the minutes in a year. It was just meant as a device. When you talk billions and billions of dollars, people don't really understand what you are talking about. When you talk $24 million a day, they begin to get a grasp of the scope of the problem we are talking about. But the figure is an actual calculation of what is happening right now.

Senator MITCHELL. As opposed to a projection?

Mr. SIMMONS. Well, it projects, obviously, the rest of the year; but we have just taken a new look at the midterm projections, and the numbers are the same. We know that in November and December we are going to have to borrow *X* number of dollars in order to make payments for those 2 months plus the months of January through June, which is all we have the authority for under the statute passed this year. So I don't think there is any quarrel over the numbers.

I can give you a piece of paper that will show you how that was arrived at; but the fact of the matter is that the trust funds are being depleted at that rate, and this is the very reason why we have the National Commission looking at what we can do about it.

Senator MITCHELL. I understand that, Mr. Simmons. But I would like to get a statement from the actuaries that says precisely how that is calculated.

[The following was subsequently supplied:]

The most recent estimates of the financial status of the Social Security trust funds, using the assumptions underlying the Mid-Session Review of the President's FY 1983 budget, show that in calendar year 1982 the combined old-age, survivors, disability and hospital insurance trust funds will have an excess of outgo over income of about $8.8 billion. If one divides $8.8 billion by the number of minutes in a year (525,600), the result is $16,743, which rounds to $17,000. That is the basis for the statement that the Social Security funds are losing $17,000 a minute.

Mr. MITCHELL. Is my time up, Mr. Chairman?

Senator ARMSTRONG. We are operating under a very relaxed rule, Senator. Please continue with your questions.

Senator MITCHELL. Well, I only have one more question I would like to ask.

Earlier, I believe you, Mr. Simmons, and Mr. Hays testified before Senator Cohen's committee, and this is a problem which obviously is the reason for the legislation and the reason for the hearings and for much of the controversy over the two standards: You have the States operating under one system and the administrative law judges using another standard.

In that hearing there was some questioning and some of your answers regarding the extent to which decisions by courts—up to and including Federal courts of appeals—are adhered to. I have a special interest in that, and I wonder if you would explain to me how that occurs. The answer you gave was that, in effect, in some cases you acquiesce in court decisions and follow them, and in others you don't. Perhaps either of you could give a brief explanation of that.

Mr. SIMMONS. Why don't you address that first?

Mr. HAYS. Senator, we follow in our department—and it is not a new policy, it is a longstanding one—what I understand to be the traditional Federal position with respect to a national Federal program; that is, there is a single Federal law which the Congress has enacted and has charged the Secretary of Health and Human Services with carrying out that uniform national program pursuant to the Federal law. That means, as a general proposition, we feel that decisions in disability cases must be made on the basis of that uniform national policy, even though there might in fact be a U.S. district court decision that might be contrary to that national policy.

Obviously, in a given case involving the parties to that lawsuit, we follow what the court says; but in other cases we do not. Perhaps the best analogy is the policy that the Internal Revenue Service follows, essentially in the same regard: acquiescing or nonacquiescing in court decisions under the theory that there has to be a single national program and that we cannot in effect discriminate against citizens just because they happen to reside in a particular Federal district of the country. We have to treat all of the people alike.

Senator MITCHELL. Well, I can understand the logic of that. Your answer referred to Federal district courts; my question referred to Federal courts of appeal.

I have always been under the impression that the law of this country is what Federal courts say it is. If you have a case that went to a Federal court of appeal, in which a decision was rendered and which whatever agency of the Government decided not to appeal, though the law in that case—fully apart from the specific facts—had precedential value with respect to another comparable case let's say, I had always been under the impression that was the law.

Mr. SIMMONS. Could I ask Mr. Gonya? He is Assistant General Counsel of the Department and is very familiar with this.

Senator MITCHELL. Fine.

Mr. GONYA. If I could supplement the comments of Mr. Hays, I think another very important factor to consider in this whole study of following court decisions is the fact that Federal district courts and courts of appeal, in reviewing social security cases, review them under the substantial-evidence test. Particularly in the disability area, you are talking, in most instances, of questions of fact.

Under the substantial-evidence test that courts are bound by, what one judge may conclude as to the disability status of an individual plaintiff who is before him in one particular case may have little bearing in the next case that follows, because of the unique facts and the different facts that come up in all of these cases.

Moreover, Senator, regarding the notion that we are bound to follow the holding in a subsequent comparable case, I would submit that there aren't that many subsequent comparable cases—particularly in the disability area—because of the very importance of the facts which must be adjudicated before that Federal court. And each plaintiff brings different facts to that review.

Senator MITCHELL. But that is true of every lawsuit in every area of the law, is it not?

Mr. GONYA. Sure.

Senator MITCHELL. I have tried and heard a lot of cases in my life, and I have never heard two exactly identical.

Mr. GONYA. But I would say it is more paramount, more unique, to a program such as the disability insurance program.

Senator MITCHELL. Well, thank you very much. And thank you, Mr. Chairman.

Senator ARMSTRONG. Of course.

Senator MITCHELL. I'm sorry to have gone a little over my time.

Senator ARMSTRONG. Not at all.

Senator Cohen?

Senator COHEN. Thank you, Mr. Chairman.

Mr. Simmons, I have a couple of questions.

You state on page 23 of your statement that in the vast majority of cases the reason people are being taken off the rolls is not because of deficiencies in the process but because they are not disabled. If that is the case, I guess I would have to ask the question: Why are you now implementing a moratorium to try to even out the caseload? Why are you recommending face-to-face appearances before the State agencies? Why are you now supporting the inclusion of pain as a consideration on the part of those people who are reviewing those cases? If the process is not deficient as it is, why make any of these changes at all?

Mr. SIMMONS. I would not make the claim that the process is not deficient; that is the reason why we are having this hearing and the reason why the House is moving on a bill. The process is deficient, for example, because it doesn't bring the claimant face-to-face with the decisionmaker. It is deficient because there may not be clear understanding on the part of the beneficiaries at times, some of them, as to what is expected, or they are not taking this seriously, or something like that. There are a lot of problems like that.

And there are some problems in some States. In many States, for example, even though we pay 100 percent of the costs of the disability determination service, and even though we have accorded them 30 percent more money this year, there are some States where Governors have been forced for political reasons to have an absolute hiring freeze even though these people really aren't State employees for payroll purposes. So there are a lot of problems. We are hoping to correct them, and we need some legislation to do it.

Senator COHEN. Right. So what you are saying, in essence, is there are deficiencies within the process that need to be corrected?

Mr. SIMMONS. That is correct.

Senator COHEN. Some can be done administratively; some have to be done through congressional action.

Mr. SIMMONS. But what I said in that statement was that in the vast majority of cases the reason people are being taken off is not because of those deficiencies. But there are horror stories coming out of some of the deficiencies in the system. No system can be perfect, but we would like to see it much better than it is.

Senator COHEN. Ms. Greenberg, you and I had a discussion several months ago about the notice requirement, and at that time I asked you whether or not we shouldn't give consideration to spelling out exactly what kind of a notification ought to be sent.

One of the recommendations of our subcommittee is that the State agency must inform the beneficiary in a detailed, clear notice why and how his or her case will be reviewed, that the review may result in the termination of benefits, what the beneficiary's responsibilities are, and that it may be advisable to seek legal assistance. You don't have any disagreement with that kind of requirement, do you?

Ms. GREENBERG. Generally speaking, the ideas conveyed in that suggestion are good.

Mr. SIMMONS. And we are working on the process. And as I say, we are looking at possibly a face-to-face process in our own 1,350 offices, where these people would be brought in, walked through the procedure, and then given very clear materials—much clearer than has been possible until now.

Senator COHEN. That sort of notification could be done now administratively.

Mr. SIMMONS. Even if we don't go to the more elaborate face-to-face operation at the local district office, there will be major changes made in the notification procedures, and they are coming very soon.

As you know, we have a tremendous problem in Baltimore with our systems. We were left with a system that doesn't "system," but we do think we have found a way to do it, and we are going to be doing it. We will be sharing those materials with the committee.

Senator COHEN. Mr. Simmons, one of the underlying implications of your testimony is that you feel that during the 1970's the agencies and the administrative law judges were too liberal in awarding benefits, in essence during the Nixon-Ford-Carter years. Is that not correct?

Mr. SIMMONS. I wouldn't characterize it as that long a span.

Senator COHEN. Only since 1976?

Mr. SIMMONS. And during the 1972 and 1974 period I was one of the people on the other side of the Federal-State table who was contributing to that by moving people off State rolls into the Federal rolls. It was a general trend among States at the time when the SSI program was being put into effect. It was a combination of things: It was a brand new program; it was a program that almost couldn't be implemented for administrative reasons, because the lead time was so short; and then the Congress changed the rules 6 months before the program was to be implemented and said, "You had to be grandfathered on; you had to be on the State rolls more than 6 months before." With that combination of events, we ended up in New York City with busloads of people sitting outside social security offices in the cold. It wasn't a question of whether it was liberal or conservative at that time, it was a question of the sheer multitude of numbers coming in, and it became "Well, just let them in; we can't possibly develop every case." Now a lot of those people are in the CDI process.

Senator COHEN. Just one final question, since my time is about to run out.

I assume by virtue of the fact that you support the Pickle bill, that you would support the inclusion of pain as a factor to be evaluated, assuming it is supported by reasonably objective medical evidence.

Mr. SIMMONS. It is one of the most troublesome areas we have, and it would be most helpful to the system and to the judges and to the courts to have something in the statute that clearly spelled out how Congress means one should evaluate pain.

Senator COHEN. The other major issue that I think needs to be addressed is the question of what is adequate medical evidence. To the extent that you only rely upon the most recent evaluation, do you agree that that in essence does not give you a fair or full, comperehensive understanding of the nature of that person's medical situation? That it, in fact, should include the entire history as updated by the most recent evaluation?

I notice the GAO was rather critical of the way in which the program was administered by not taking into account the fluctuations that could occur in someone's medical condition. If you don't see the history, and you only see that person for that moment, that could give you a very limited understanding of the nature of that person's medical condition.

Mr. SIMMONS. But, as I said earlier, beginning last May, we did respond to that concern of the GAO and our own concern and mandated that the States go back a minimum of 1 year to gather all available evidence. If the claimant wants to present more medical evidence or medical history, then the claimant can do that. But what we do is go back at least 1 year. A lot of conditions may not be relevant. And a lot of people who are on the disability rolls now may have been there for some years and aren't in active treatment, so that you would have to go way back to get something.

Senator COHEN. Mr. Chairman, if I may proceed, it relates to the question of notice.

Ms. Greenberg, I understand you hesitated; you did not want to commit yourself to my question. I should explain to the audience that this is not because you are reluctant to put people on notice. You happen to have a very real sensitivity about not shocking people. You don't want to unduly frighten somebody into thinking that their benefits are going to be terminated if, in fact, they might not be. Now, I understand that. What I am suggesting, though, is that this notice, in terms of the notions of fair play, that you should put them on reasonable notice as to what is involved, and should include some notification that they have the burden. Unless the law is going to be changed later by this committee and the Congress, they have a burden to carry. That burden will mean bringing in other evidence as well as subjecting themselves to an evaluation by the Social Security Administration.

So, to the extent that they are unaware of what burden they have of carrying forward, they are going to be severely handicapped at the time they come for review. That is the reason I am so concerned about the notice aspect, because if they don't really fully appreciate the gravity of the circumstances then they might not bring in all of that medical evidence or bring in their own doctors, or whatever.

Ms. GREENBERG. If I might just say one thing about that burden, the real burden that they have initially in most cases is just to tell us who those sources are. In almost every case the evidence is gotten by the State agency.

Senator COHEN. Thank you, Senator.

Senator ARMSTRONG. Thank you, Senator Cohen.

Mr. Commissioner, I have quite a number of questions that I am going to reserve—all but one of them.

Is it fairly typical that Members of Congress contact administrative law judges on behalf of their constituents who have appeals?

Mr. SIMMONS. It has been known to happen from time to time.

Senator ARMSTRONG. Does this happen in a large number of cases?

Mr. SIMMONS. I don't know if we would ever know a count on something like that. We don't go snooping in mailboxes and looking at phone logs; but judging by the volume of mail that I get from Congressmen on behalf of administrative law judges and on behalf of claimants with the name of the judge involved, I would say that the contact must be quite heavy.

Senator ARMSTRONG. Would there be anything that a Member of Congress could say to an administrative law judge about the case of a particular person whose case was under appeal which would constitute a proper form of evidence?

Mr. SIMMONS. Ideally, under law, the Congressman could not put pressure on a judge, say, to rule favorably in the case of a claimant. I'm getting into sticky ground here, but there is nothing that a Congressman says—unless the Congressman says, for example, "I referred this person to my brother the neurosurgeon, and he tells me so and so"—which may be a new piece of evidence. But there have been rumors from time to time that perhaps some influence has been brought to play in some isolated cases. But I wouldn't characterize it as being a widespread problem.

Senator ARMSTRONG. You wouldn't characterize it as what kind of a problem?

Mr. SIMMONS. As a real widespread problem. But obviously a Congressman or a Senator is going to serve his constituents and is going to write a letter, if that is the appropriate action, to anybody—to me or to a State agency. I have had conversations with State legislators in States I have worked in who have also had very close relationships with the offices of their local ALJ.

Senator ARMSTRONG. Do you know, or do any of those who have accompanied you to this hearing today know whether or not to any extent these contacts have in fact influenced the opinions of adminstrative law judges?

Mr. HAYS. I would certainly hope that it would not have influenced the decisions of our administrative law judges. Obviously I am not in a position to attest to that fact, but I think our administrative law judges are honest men and women of integrity who, while they want to provide service to their Congressmen by trying to handle their cases quickly, are not going to decide a case one way or the other because of the way a Member of Congress might prefer.

Senator ARMSTRONG. Do any of my colleagues on the committee want to comment on that or have any information on this point?

[No response.]

Senator ARMSTRONG. I have heard it whispered that this is a fairly common kind of thing, and there are even some people who believe—I do not attest to this because I don't have any information on the point—that a letter from a Congressman to an administrative law judge will be decisive in the determination of at least some cases before some ALJ's. I stress, and I don't want to mislead anybody, I don't have the slightest information on this subject other than the fact that I do know that there are some people who believe that to be the case.

The reason I raised the question is because I am very much concerned, as my colleagues are, about the seemingly rather large number of reversals. Now, I am aware of the fact that there are many other reasons for these reversals: that it is the first face-to-face confrontation, that it is the first time that many people really know that their benefits may be withdrawn, that they have the opportunity to present new medical evidence, and all of that. But I would ask, Commissioner, that you reflect upon this question of the influence of Members of Congress upon the administrative law process, and perhaps we could discuss it on some other occasion. If there is no impropriety, then I don't mean to suggest it; but on the other hand, I wonder whether or not whatever legislation we finally undertake ought to contain some kind of standards for what is a proper kind of official conduct and contact with these judges and what it is not. Maybe there are already such provisions that I am not even aware of.

Senator **MITCHELL**. Mr. Chairman, could I inquire, do you know from your knowledge, Mr. Chairman or Mr. Simmons, whether Members of Congress write to persons involved in the decisionmaking process prior to the administrative law judges?

Mr. **SIMMONS**. Prior to the decision?

Senator **MITCHELL**. Yes.

Mr. **SIMMONS**. Oh, yes. That is not an unusual practice, either written communication or verbal. And also they write to State agencies. States will write to us and tell us, "We know about this case; we just got a letter," and that is still at the State agency level. We get a lot of mail like that.

Senator **MITCHELL**. So, looking at a hypothetical, if a Member of Congress wrote a State decisionmaker and to the administrative law judge, one would think that the Congressman's participation would be relatively neutral and not be the reason for one reaching one decision and the other reaching another, unless we assume that the State decisionmaker is somehow less subject to influence than the judge. Is that not the case?

Mr. **SIMMONS**. Well, the State decisionmaker his or herself may not necessarily see the letter, but someone certainly does in the agency. When I was in the New York State welfare agency we would call those "congressionals," and of course they got expedited treatment, and all that. It is a wonderful thing what a franked envelope can do for speeding up the bureaucratic machinery. But I would like to reflect on it, as the Senator suggested, and perhaps discuss that further at some point.

Senator **MITCHELL**. I think include the whole process, though—reflect on the whole process, not just the judges.

Senator **CHAFEE**. Mr. Chairman?

Senator **ARMSTRONG**. Yes.

Senator **CHAFEE**. I just wanted to ask a brief question of Mr. Simmons.

On page 16 of your testimony you talk about the Appeals Council reviewing the ALJ decisions and finding defects, and so forth. Who decides? What percentage of the decisions of the ALJ are reviewed?

Mr. **HAYS**. We currently review approximately 50 percent of all of the ALJ decisions which deny benefits to claimants, and approximately 15 percent of all ALJ decisions which grant benefits to claimants.

Senator **CHAFEE**. Thank you.

Senator **ARMSTRONG**. Unless there is something further for these witnesses, we thank you for your testimony.

Mr. **SIMMONS**. Thank you, Senator.

Senator **ARMSTRONG**. Thank you for your testimony and for your participation.

[The further questions of Senators Armstrong and Heinz and answers of Commissioner Simmons follow:]

DEPARTMENT OF HEALTH & HUMAN SERVICES
Social Security Administration

Refer to SRP-1
Office of the Commissioner
Baltimore MD 21235

Honorable William L. Armstrong
Chairman, Subcommittee on Social Security
  and Income Maintenance Programs
Committee on Finance
United States Senate
Washington, D.C. 20510

Dear Senator Armstrong:

Enclosed are responses to your questions submitted subsequent to the Senate Committee on Finance's August 18 hearing on the Social Security Administration's continuing disability investigations process.

If I can be of further assistance, please let me know.

Sincerely,

Paul B. Simmons
Deputy Commissioner
  for Programs and Policy

Enclosures

Question 1

Do you feel the Reagan Administration had any significant discretion in whether and how the 1980 provision was to be implemented?

There was very little discretion - the 1980 amendments were very specific about the cases to be reviewed and the time limit for reviewing them. In addition, existing law is very detailed and firm in defining disability both for new applicants and those on the rolls who are to be reviewed. It is the strictest definition of disability of any Government program and is more strict than many private disability insurance policies. Any administration which implemented the periodic review provisions of the 1980 amendments would have experienced adverse reactions from those who were terminated. What little discretion there is under the law is being used to ease the impact of the continuing disability investigation (CDI) reviews on beneficiaries. For example, we have:

-- improved our selection criteria so that more beneficiaries who are permanently disabled are identified and exempted from the 3-year periodic review process;

-- changed our policy on terminations so that, in general, we determine that a person's disability ceases as of the time we notify the beneficiary of our determination, rather than making retroactive determinations that disability ceased and that past disability benefits must be repaid;

-- decided to conduct face-to-face interviews in our local offices for every beneficiary selected for a CDI to ensure that beneficiaries are told early in the CDI process what to expect and that cases selected for review are appropriate ones;

-- continuously monitored State agency resources and workloads to adjust the flow of cases as necessary. In August and September (and earlier in some States) we put a selective moratorium on referral of CDI cases to States with unusually large CDI backlogs. This moratorium was possible because the administration began the mandated review process in March 1981, 9 months earlier than necessary, thus gaining more time to complete the initial review of the disability rolls within the 3-year period mandated by Congress;

-- reduced by 20 percent the number of CDI cases to be reviewed by State agencies in FY 1983 in order to ease the workload burden and allow States more time to develop medical evidence in each case.

Question 2

We have recently been informed that ineligibles in the DI program might exceed 30 percent. Do you think this is a quirk in the sample or a strong indication that a problem really does exist in the DI program?

The evidence is overwhelming that the problem of ineligibles on the DI benefit rolls is a very serious one. SSA has conducted two studies of disabled beneficiaries and both indicate that about 30 percent of the disability beneficiary population is not disabled. The CDI Redesign Study, conducted in 1980 and 1981, was a study of 25,000 cases (which represented 60 percent of all disabled beneficiaries). This study found that 33 percent of beneficiaries in the study universe did not meet the requirements of the law. The DI Pilot Study II, conducted in 1981, was a statistically valid random sample study of 2,800 cases (which represented 100 percent of disability beneficiaries). This study found that 30 percent of beneficiaries on the rolls did not meet the requirements of the law.

Our experience to date under periodic review supports the results of our studies. The overall cessation rate for periodic review cases from the beginning of FY 1982 through July 30, 1982 was 43.1 percent; for the 4-week period ending July 30, 1982, the cessation rate was 41.4 percent. The cessation rate has been running well above 30 percent because cases initially selected for review are those with the highest likelihood of ineligibility.

Question 3

Do you feel that any legislation is needed to alter the 1980 measure calling for a periodic review of a disabled beneficiary's eligibility? What provisions of the several House and Senate bills already proposed would the Administration support?

We do not believe legislation is needed to alter the basic periodic review requirement which has emerged from concern, on the parts of the Congress, GAO, and administrations of both parties, that huge sums are being incorrectly paid to individuals who are not disabled under the law. Overall, the periodic review is manageable and moving well and most problems have been resolved.

The accuracy of our CDI reviews has been very good. Our quality assurance review found that in the 6-month period ending March 1982, 97.5 percent of CDI determinations were correct.

Although State agency processing times for initial decisions rose from 44.6 days in the first quarter of 1981 to a high of 50.3 days in the first quarter of 1982, they decreased to 45.6 days for the quarter ending June 1982. The selective moratorium on new periodic review cases that SSA implemented for August and September (and even earlier in some states) has been easing problems in specific states, as will the 20 percent reduction in the number of CDI cases to be reviewed by State agencies in FY 1983 announced by Secretary Schweiker and Commissioner Svahn on September 8, 1982.

SSA has geared up for the CDI periodic review workload with staff and resources. Between March 1981 and March 1982, SSA increased State agency staffing by 2,045 positions. The additional staff is trained and working. Therefore, legislation to reduce the number of reviews further and slacken the process would be wasteful of resources for the long run.

While we do not support legislation to alter the basic periodic review requirement, we do support legislation, which, together with administrative reforms SSA is making in the CDI review process, is designed to ease the impact of periodic review on beneficiaries whose cases are selected for review.

The administration supports all of the provisions of H.R. 6181 with the exception of sections 3, 9, and 12. These sections would: (1) Increase the costs of the Social Security system by extending disability benefits for an additional 4 months for those people who have collected benefits for 3 or more years and were terminated because of medical recovery; (2) restrict program discretion by automatically indexing the substantial gainful activity level used in determining eligibility for DI and SSI benefits; and (3) unnecessarily expand vocational rehabilitation services for which Federal funds can be used.

Chief among the provisions of H.R. 6181 which we support are the requirements that: (1) a face-to-face evidentiary hearing be held at the reconsideration level appeal of State agency disability determinations, and (2) disability benefits be continued for up to 6 months during the reconsideration process (or until the reconsideration decision, if earlier). These provisions would enable us to proceed with the CDI review program in a responsible, responsive manner so that we can remove ineligibles from the rolls promptly and at the same time adequately protect the rights of those who are truly disabled under the law.

Some other bills relating to the CDI process which have been introduced in the House and Senate contain provisions similar to the provisions in H.R. 6181 which we support, and we would consider these provisions to be reasonable and constructive.

Question 4

GAO, in a July 14 letter to the Secretary, recommended changes in the notification to beneficiaries, changes in policy to ensure complete medical histories are obtained for periodic reviews, and changes in processing time goals for periodic reviews. These recommendations address some of the concerns heard at the August 18 hearing. What is your position with respect to the GAO recommendations and how soon could they be implemented?

The GAO recommendations and our comments are:

1. Notify all disability beneficiaries of purposes of periodic review, and the importance of their providing complete and current medical evidence and of the fact that little consideration will be given to the prior determination.

   SSA agrees with this recommendation and is taking steps to carry it out. As mentioned in the response to question 1, beginning October 1, 1982, SSA's field offices will conduct face-to-face interviews with every beneficiary selected for a CDI. We believe this will be the most effective way of notifying a beneficiary of what to expect during a CDI and of what the beneficiary's rights and responsibilities are.

2. Issue policy guidance to the State agencies emphasizing the uniqueness of the Periodic Review cases and the need for a full medical history in all cases covering the period from the initial disability determination and include medical information used in the initial determination.

   We review all evidence in file including that submitted in connection with the initial application. The emphasis when obtaining new medical evidence, however, is in getting a full picture of the claimant's current condition. We do this by obtaining all medical evidence of record for the last 12 months. For conditions subject to exacerbation or remission, earlier evidence may be obtained, depending upon the facts in the individual case. Complete compliance with the GAO recommendation could mean, for example, obtaining 10 years of medical records for an individual with a chronic or static condition. That kind of development would be costly and time-consuming and would not give a better picture of the person's current status than our present procedures.

3. Establish a processing time goal for managing the Periodic Review caseload that is commensurate with thorough development of medical evidence.

   We agree that any processing time goal for CDI's should be commensurate with thorough development of medical evidence. At present, we do not have processing time goals for CDI's because our management information system cannot measure CDI processing times. However, we are in the process of modifying the system; once the modifications are made, and we have collected sufficient data on the range of processing times in the State agencies, we will establish processing time goals.

Question 5

It has been argued by a number of persons that a DI beneficiary should not be terminated from the rolls unless the Social Security Administration can show that he has medically improved. Do you believe this would be a sound policy to follow for the DI program? Wouldn't such a policy be inequitable toward those persons (with similar impairments) who can't get into the program today?

Such a policy would be inequitable because a person on the rolls could continue to get benefits while a person with the same impairment who is either now applying for benefits or who already had benefits terminated as a result of a CDI could not receive benefits. More importantly, a requirement for medical improvement would undermine a basic eligibility requirement--that beneficiaries meet the definition of disability in the law. In light of SSA and GAO studies showing that huge sums of disability benefits are being paid incorrectly (as much as $4 billion a year), we believe that it would be unconscionable to pay benefits to people SSA knows are not disabled because they are able to engage in substantial gainful activity. It is clear that substantial numbers of people were put on the benefit rolls erroneously, especially in the 1970's with the advent of the black lung and SSI programs when there was tremendous pressure to process claims quickly and reduce backlogs.

Any requirement for medical improvement, by creating different definitions of disability for initial claims and for CDI's, would significantly complicate administration of the DI program and add to an already confused public perception of the program. Administration would be further complicated and CDI claims processing times lengthened because of the difficulty of comparing a person's current condition with his/her condition at the time he/she was put on the rolls. Frequently, data from the time the original decision was made is inadequate or difficult to compare with current information, e.g., because of changes in regulatory requirements or improvements in medical technology, comparable information was not needed or did not exist in the past.

Question 6

Do you support or find administerable any of the recent proposals for a medical improvement standard or for elevating to higher appellate levels those cases where the State cannot show medical improvement, but believes the individual is nevertheless not disabled?

For the reasons discussed in our response to question 5, we would not support any requirement that medical improvement be shown before disability benefits could be terminated. Administrative difficulties with such a requirement are also discussed in that response.

We also would not support referring cases to higher appellate levels for review where the State agency finds that a person is not disabled but the State agency cannot show medical improvement. First, since the State agencies would have to determine whether or not there was medical improvement in every case, the significant administrative burden (discussed in the response to question 5) of comparing every beneficiary's current condition with his condition at the time he/she came on the rolls would be present. Second, all levels of adjudicators are bound by Social Security law and regulations, neither of which require medical improvement before benefits can be terminated. Thus, we see no merit to establishing a special two-level initial adjudicatory process for these cases. If a person is not satisfied with SSA's decision, he/she has the right now to appeal to a higher level.

Question 7

Pressure to process claims quickly and reduce backlogs resulted, according to your statement, in the highest disability incidence rate in the history of the program in the 1970's. Now it is claimed that those same pressures are producing the opposite effect at the State agency level--a higher termination rate. Is it possible for both claims to be true or is something being overlooked?

The high termination rate for CDI cases is not due to pressures to process claims quickly and reduce backlogs. The high rate for CDI's is consistent with studies conducted by SSA that indicate that at least 30 percent of disabled beneficiaries are not disabled. The rate has been higher than 30 percent (currently the rate is 41.4 percent) because the CDI's have been targeted at cases most likely to result in a finding that the person is not disabled. The termination rate has already dropped from the 48.2 percent rate in the September 1981 calendar quarter, and is expected to continue dropping as less error-prone cases are selected for CDI's. Further, SSA's quality review process indicated that State agency CDI decisions have been highly accurate; in the 6-month period ending with March 1982, 97.5 percent of State agency CDI decisions were correct.

There is a very important difference between the situation in the 1970's and the situation today--SSA has implemented the periodic review requirement with sufficient staff and other resources to handle the additional workload. Between March 1981 and March 1982, SSA increased State agency staffing by 2,045 equivalent full-time positions.

SSA has not put pressure on State agencies to process CDI cases quickly and reduce backlogs. As we pointed out in the response to question 4, we do not as yet have any CDI time processing goal for State agencies. Further, SSA has consistently monitored State agency resources and workloads closely and adjusted the flow of cases to the individual states to avoid backlogs when problems have arisen. The selective moratoriums on new CDI cases that SSA has implemented for August and September (and even earlier in some States) have been easing problems in specific States that have had unusually large backlogs. Also, SSA will reduce by 20 percent the number of CDI cases to be reviewed by State agencies during FY 1983.

Question 8

What evidence do you have on the variation in State agency workloads and backlogs of cases? Is there considerable variation in the way States are responding to the increased workload--are they processing the reviews or simply letting them pile up?

SSA gathers considerable data each week on State agency workloads through the State Agency Operations Report. In addition, SSA regional office personnel make periodic onsite visits to review State agency operations. These actions enable us to closely monitor the workload situation in each State so that we can detect possible problems and take appropriate action.

There have been significant variations in the way States have been responding to the increased CDI case workload. Some have experienced considerable problems in processing the cases and consequently have large backlogs. Others have managed their case workloads very well and have practically no backlogs. The problems are due to a variety of reasons. Some States have had hiring freezes so that even though SSA has supplied them with sufficient resources to handle the CDI workloads, they have not been able to hire sufficient staff to process the cases. Other States have concentrated their resources on processing initial disability cases, rather than CDI's, because the Federal/State regulations impose quality and quantity performance standards for initial cases but not for CDI cases. This will be corrected when we have established an adequate data base, as discussed in the response to question 4.

The Regional Commissioners are working with the States to help them solve problems they are experiencing in order to keep the flow of CDI cases as smooth as possible. In addition, as discussed in the response to question 7, we have put selective moratoriums on new CDI's in some States, and have reduced the number of CDI's we expect the States to process in FY 1983.

Question 9

Do we have any evidence on whether or not the heavy CDI workload leads to more lenient or more strict decisions? It was argued that the heavy workload in the mid-1970's associated with the enactment of the Supplemental Security Income program led to lax administration and more lenient decisions.

We have no evidence of any cause and effect relationship between the size of workloads in the State agencies and the nature of the State agency decisions. While it is true that in the mid-1970's there were very heavy workloads and a very high disability incidence rate, we attribute that incidence rate to the tremendous pressure at the time to process the workload quickly and yet hold down processing costs, and the lack of any effective process to monitor the quality of State agency decisions.

In the mid-1970's, there were few reviews of State agency disability decisions; today we have Federal quality assurance reviews of initial, reconsideration, and CDI decisions, and, as mandated by law, pre-effectuation reviews of a percentage of all favorable Social Security decisions made by the State agencies. The quality assurance reviews consist of approximately 5 percent of all State agency decisions and the pre-effectuation reviews consist of 35 percent of all State agency decisions favorable to the claimant. In the case of CDI cessations, we have doubled the number of quality reviews of termination cases. These reviews assure that a very high percentage of all State agency decisions are accurate, and that they are based on adequate medical documentation.

SSA has made many other administrative improvements in the way we manage the disability program that have resulted in better documentation and evaluation of cases by State agencies. For example, in 1978, we published regulations supplying additional detailed criteria for the evaluation of disability claims in which a determination cannot be made on medical severity alone or on the claimant's ability to do past work (the so-called "vocational grid"). In 1979, we published regulations updating the listing of impairments which, in and of themselves, are considered disabling, absent evidence to the contrary. We are in the process of further updating those regulations right now. We have also used various other management processes such as more explicit instructions, requirements for better documentation and increased physician participation in adjudication and review.

Question 10

Is it true, as some have argued, that the changes made in recent years in the regulations pertaining to the so-called "medical listings" and "vocational factors" caused an unintended tightening of the program? To what extent do they merely reflect changes in medical science and diagnostic techniques?

The changes made in the medical listings are intended to reflect advances in the medical diagnosis and treatment of some conditions and in the methods of evaluating certain impairments. The changes in some cases are intended to improve the quality of disability adjudication by clarifying how certain medical impairments should be evaluated, based on program experience with the prior listings.

The changes made in 1978 in the regulations concerning the evaluation of vocational factors (the so-called "vocational grid") were not intended to reduce the number of favorable decisions. Rather, the changes were intended to consolidate and elaborate upon long-standing medical-vocational evaluation policies. The new regulations presented the policies in more detail by the use of charts showing the interaction of age, education, and work experience in arriving at a disability determination. There is no clear trend towards fewer allowances based on vocational considerations since the new regulations became effective in 1979.

Question 11

It is frequently suggested that the high rate of reversal of State agency decisions by administrative law judges reflects, in effect, a high "error rate" at the State agency level. What evidence do we have that ALJ's make better or more accurate decisions than State agencies? Is legislation needed to bring about more uniformity between State agency and ALJ decisions?

While it is true that the ALJs reverse the earlier determinations in about half of the cases they review, this does not necessarily indicate a high error rate in State agency determinations; nor is there any evidence to suggest that the quality of decisionmaking at the ALJ hearing level is superior to that at the State agency level. To monitor the performance of State agencies in making disability decisions, SSA performs a quality assurance review. Under this review, 97.5 percent of State agency initial disability determinations in the quarter ending March 1982 were found to be correct. In the 6-month period ending March 1982, 97.1 percent of State agency reconsideration disability determinations were correct.

There are a number of factors which can result in allowances at the hearing level for reasons other than errors made by State agencies or by ALJ's, including the subjectivity of the decisionmaking process, the face-to-face contact which first occurs at the hearing level, the possibility of progressive worsening of the medical condition and the fact that additional evidence often becomes available at the hearing level for the first time. In addition, the ongoing review of ALJ allowance decisions mandated by the Bellmon Amendment has revealed errors serious enough to warrant reversal or remand to the ALJ in approximately 19 percent of the cases reviewed.

Another cause of the discrepancy between State agency determinations and ALJ decisions is the lack of uniform adjudicatory standards for disability determinations. We are now in the process of issuing a series of Social Security Rulings to remedy this problem. These Rulings will provide agency-wide guidelines for adjudicating disability claims and should promote greater uniformity in decisionmaking at all levels. There is ample statutory authority as well as precedent for issuing agency policy directives in this manner, so new legislation is not necessary.

DEPARTMENT OF HEALTH & HUMAN SERVICES
Social Security Administration

Refer to SRP-1

Office of the Commissioner
Baltimore MD 21235

Honorable John Heinz
Chairman, Senate Special Committee on Aging
United States Senate
Washington, D.C. 20510

Dear Senator Heinz:

Enclosed are responses to your questions submitted subsequent to the Senate Committee on Finance's hearing on the Social Security Administration's continuing disability review process.

If I can be of further assistance, please let me know.

Sincerely,

Paul B. Simmons

Paul B. Simmons
Deputy Commissioner
for Programs and Policy

Enclosures

Question 1

SSA has testified that, based on a recent quality review study, the accuracy rate of the CDI decisions is 97.5 percent with a 2.5 percent error rate. All the evidence indicates, however, that there is substantial disagreement among decisionmakers as to whether the same individual is disabled or not. In SSA's Pilot Study #1, the same cases were put through two independent reviews. In those cases where the individual was found during the first review as not being disabled, the second reviewers agreed only 60 percent of the time that the individual was not disabled. In 40 percent of the cases, there was disagreement between the two reviewers. In the 1982 Bellmon Report to Congress, SSA found: "The major finding of the initial review was that significant differences in decision results were produced when these different decisionmakers were presented with the same evidence on the same cases. The ALJ's (administrative law judges) allowed 64 percent of the cases. The Appeals Council, applying ALJ standards, allowed 48 percent. OA (SSA's Office of Assessment) applying DDS (State Agency) standards, allowed only 13 percent".

What does the Office of Assessment consider to be an "error"? Is it an "error" when the administrative law judges subsequently allow a claim which the Office of Assessment believed was correctly denied? How do you reconcile this very small error rate with all the evidence that indicates that anywhere from 40-65 percent of the terminations could be viewed as "incorrect" terminations when evaluated by a different decisionmaker?

The Office of Assessment (OA) conducts quality reviews of State agency disability decisions and of payments to disability beneficiaries. In determining the accuracy rates of State agency decisions, OA considers only the evidence in the cases that was available to the State agency when it made the disability determination. Deficient cases are those in which the medical and vocational documentation supports a different decision than that made by the State agency or in which missing medical or vocational documentation could potentially reverse the State agency decision.

The quality reviews of State agency decisions show net accuracy rates of 97 percent on initial disability claims for the quarter ending March 1982, 97.1 percent on reconsideration cases for the 6-month period ending March 1982, and 97.5 percent on continuing disability investigations for the 6-month period ending

March 1982. The "net accuracy rate" reflects the percentage of cases reviewed in OA in which the State agency decision was correct including cases where additional documentation was obtained.

A reversal of the State agency decision by an ALJ (or higher level of appeal) is not considered in determining the accuracy of the State agency decision. To do so would be improper since there are a number of factors which can result in allowances at the ALJ level for reasons other than errors made by State agencies, including the subjectivity of the decisionmaking process, the face-to-face contact which first occurs at the hearing level, the possibility of progressive worsening of the medical condition and the fact that additional evidence often becomes available at the hearing level for the first time. In addition, the ongoing review of ALJ decisions mandated by the Bellmon Amendments to the 1980 disability amendments has revealed ALJ errors serious enough to warrant reversal or remand to the ALJ in approximately 19 percent of the cases reviewed.

Another cause of discrepancy between State agency determinations and ALJ decisions is the lack of uniform adjudicatory standards for disability determinations. As you have pointed out, this was a major finding in SSA's 1982 report to the Congress on the results of the Bellmon study and we are taking steps to remedy this problem.

SSA's DI Pilot Study I, which you have cited as an example of substantial disagreement among decisionmakers as to whether an individual is disabled or not, was designed to test methods of quality review of payments to current disability beneficiaries and to identify problems before establishing an ongoing quality review. (It was not designed to measure the accuracy of State agency decisions.)

Analysis of the DI Pilot Study I cases in which there was disagreement indicated that the cases involved problems of inadequate or conflicting medical evidence or difficulties in applying concepts of residual functional capacity or vocational factors. Most of these problems with the quality review process were eliminated in the DI Pilot Study II by requiring new consultative medical examinations in all cases except those involving permanent disability, making sure OA reviewers had adequate experience in evaluating residual functional capacity, and by doing more intensive reviews of difficult cases involving the application of vocational factors. As a result of these improvements in quality review, the disagreement rate was reduced to 5 percent and is expected to remain the same in the ongoing quality review of payments to disability beneficiaries.

Question 2

It is my understanding that the physician employed by the State agency makes the determination of the so-called "residual functional capacity," which is the determination of what grade of work an individual with a severe impairment can nevertheless perform. At a recent meeting in Boston of the Administrative Law Judges in charge of the New England Region, an SSA regional official stated that, on the average, the State agency physicians spend about 10 minutes reviewing the disability file. Do you think 10 minutes is sufficient for a physician to review the file and render a careful, thoughtful decision about an individual's work capacity?

We do not measure the performance of State agency physicians on the basis of minutes per case. The amount of time a physician spends on each case depends on the case. In general, the State agency physician's role is fourfold: to help the Disability Determination Service (DDS) staff interpret the meaning of medical evidence, to determine the need to purchase consultative examinations, to assess the issue of residual functional capacity, and to concur in the final disability determination. In individual cases where the file is complete and clear, the amount of physician time could be quite small. In other cases where evidence is inadequate or the decision a close call, the physician may be required to spend considerable time on them. Therefore the concept of average time per case is not particularly meaningful. It is possible that the statement referred to was misinterpreted since our national DDS budget was recently increased to reflect additional time required for State agency physicians to improve the documentation of residual functional capacity determinations. On budgetary terms, this additional time works out to about 10 minutes per case, but that is not average time for physician case review.

Question 3

Would you please supply the most current data showing the number of CDI cases sent, decided, and pending before the State agencies, along with the termination rates, on a State-by-State basis? We would also like to know the current number of cases pending before the Administrative Law Judges.

The attached table contains the requested information on CDI cases in the State agencies.

We do not maintain an actual count of the number of CDI cases pending at the ALJ hearing level. However, based on projections from the percentage of the overall hearing caseload involving CDI's, we estimate that out of over 150,000 cases currently pending at the hearing level, approximately 38,000 are CDI's.

TITLE II AND XVI
CDI WORKLOADS - OCTOBER 1, 1981 THROUGH JULY 31, 1982
FISCAL YEAR 1982

		Dispatched	Decisions	Pending	Cessation Rate
UNITED STATES		303,700	349,892 1/	233,148	45.2
Boston	Connecticut	2,285	3,430	875	41.3
	Maine	1,721	2,298	462	40.5
	Massachusetts	7,020	6,825	6,650	37.3
	New Hampshire	950	1,790	330	31.0
	Rhode Island	1,482	1,123	1,014	43.7
	Vermont	776	1,017	341	31.7
	Regional Total	14,234	16,483	9,672	38.0
New York	New Jersey	10,548	7,474	10,292	52.0
	New York	27,218	23,872	38,165	51.4
	Puerto Rico	8,900	10,521	5,616	72.1
	Regional Total	46,666	41,867	54,073	56.7
Philadelphia	Delaware	606	321	1,038	32.5
	District of Columbia	579	637	236	40.3
	Maryland	3,729	2,874	6,075	33.9
	Pennsylvania	11,871	13,446	15,231	44.3
	Virginia	6,849	8,497	2,550	41.5
	West Virginia	4,615	4,858	3,989	43.9
	Regional Total	28,249	30,633	29,119	42.3
Atlanta	Alabama	7,286	10,076	4,380	42.4
	Florida	11,933	9,768	19,304	45.3
	Georgia	8,895	11,668	3,386	46.4
	Kentucky	7,788	4,920	8,340	40.3
	Mississippi	4,904	6,630	1,583	41.0
	North Carolina	8,745	14,359	4,353	38.6
	South Carolina VR	4,503	7,233	1,660	41.1
	Blind				
	Tennessee	8,841	9,353	5,697	41.7
	Regional Total	62,895	74,007	48,703	42.2
Chicago	Illinois	12,929	15,917	4,704	47.5
	Indiana	6,842	5,013	7,205	46.2
	Michigan	13,306	15,026	6,817	44.4
	Minnesota	4,091	5,636	1,398	32.9
	Ohio	18,063	17,385	7,648	42.3
	Wisconsin	4,996	4,234	6,463	50.3
	Regional Total	60,227	63,211	34,235	44.1
Dallas	Arkansas	5,184	6,405	3,161	51.5
	Louisiana	7,242	10,727	2,128	54.0
	New Mexico	1,384	2,007	574	58.2
	Oklahoma	4,316	5,416	3,441	47.7
	Texas	14,536	14,126	16,153	50.8
	Regional Total	32,662	38,681	25,457	51.7
Kansas City	Iowa	2,378	2,914	1,024	35.6
	Kansas	1,461	2,019	691	40.1
	Missouri	7,347	10,772	2,306	39.0
	Nebraska	1,500	2,901	437	33.2
	Regional Total	12,686	18,606	4,458	37.7
Denver	Colorado	2,953	3,713	1,652	39.0
	Montana	1,021	1,472	364	40.7
	North Dakota	575	1,015	53	38.1
	South Dakota	791	1,208	90	22.8
	Utah	893	1,790	291	37.4
	Wyoming	303	468	70	31.7
	Regional Total	6,536	9,666	2,520	36.5
San Francisco	Arizona	2,451	5,429	1,517	39.0
	California	28,284	38,206	19,439	48.1
	Guam				
	Hawaii	861	964	332	28.2
	Nevada	723	1,286	228	43.5
	Regional Total	32,319	45,885	21,516	46.5
Seattle	Alaska	243	345	112	29.1
	Idaho	760	1,403	193	48.3
	Oregon	1,952	3,364	845	38.5
	Washington	4,271	5,741	2,245	34.2
	Regional Total	7,226	10,853	3,395	37.2

Form SSA-2854 (7-78) (Formerly CO-1770) (Destroy prior editions)

1/ This number includes cases dispatched prior to 10/81.

Senator **Armstrong**. May I next call Mr. Edward A. Densmore, Deputy Director of the Human Resources Division, General Accounting Office.

Mr. Densmore, if you would come forward, we are very much interested to hear if you can enlighten us about this subject.

Mr. Densmore, we are delighted to have you with us. Thank you for coming. Please proceed in any way that you think is most helpful.

STATEMENT OF EDWARD A. DENSMORE, DEPUTY DIRECTOR, HUMAN RESOURCES DIVISION, GENERAL ACCOUNTING OFFICE, WASHINGTON, D.C.

Mr. **Densmore**. Thank you, Mr. Chairman. We have a statement that we would like to submit for the record, but I will summarize.

Senator **Armstrong**. We would be glad to have your statement and we will put it in the record.

Mr. **Densmore**. I would like to introduce, on my right, Mr. Barry Tice, who is a supervisory evaluator in our Human Resources Division; Mr. Bob Wychulis, also a supervisory evaluator in our Human Resources Division; and on my left Mr. Terry Davis from our Cincinnati regional office.

Because of the concerns expressed to us by several Members of the Congress over the medical conditions of the large number of beneficiaries being terminated from the rolls as part of the CDI effort, in January 1982 we began to review SSA's policies and practices for conducting these investigations.

We met with State officials and examiners in California, New York, Pennsylvania, and Ohio and examined approximately 100 case folders. In addition, we met with several administrative law judges and SSA officials.

In the past, SSA's primary means of identifying beneficiaries who may have medically recovered or regained the ability to work, and assessing their continuing eligibility for disability benefits, was through the "medical reexamination diary process." This process involved establishing a future medical reexamination date for beneficiaries with certain medical conditions that were believed to have a high potential for medical improvement. When the diary date matured, State agencies were to reevaluate the beneficiaries' medical condition. Investigations were also to be done when it was learned that a beneficiary had returned to work.

We reported to the Congress in March 1981 that SSA had not adequately followed up on disability insurance beneficiaries to verify that they remained disabled.

SSA had limited its investigations to a small percentage of beneficiaries, and even beneficiaries who met the criteria for reexamination had not always been investigated. Only about one of every five persons awarded disability was targeted for reexamination.

Based on a nationwide sample case review conducted in 1979, SSA estimated that as many as 20 percent of the persons on the disability rolls did not meet the disability criteria. Based upon this sample, we estimated that as many as 584,000 persons were not eligible for benefits costing the disability trust fund over $2 billion annually.

SSA conducted a followup study in 1980 and 1981 and estimated that about 26 percent of the beneficiaries on the rolls during the July to September 1980 period were not disabled. SSA estimated from this study that erroneous disability payments amount to about $4 billion annually.

Congressional concern over the high degree of selectivity in designating cases for medical reexamination and other inadequacies in the review procedure led to the enactment of section 311 of Public Law 96-265, known as the Social Security Disability Amendments of 1980. This section required that beginning January 1, 1982, SSA review the status of disabled beneficiaries whose disability has not been determined to be permanent at least once every 3 years. SSA began reexamining beneficiaries in March 1981 under an accelerated CDI review.

SSA selected about 451,000 cases for investigation between March 1, 1981, and May 31, 1982. The States have completed investigations and have made decisions on about 240,000 cases, resulting in the termination of benefits in about 106,800 or 44 percent of the cases reviewed. This is in addition to the regular investigations of about 155,000 diaried cases per year that were determined to be subject to medical improvement.

The Office of Hearings and Appeals has been tracking CDI cases through the appeals process. Its data showed that for the period February through May 1982 the ALJ's adjudicated 16,200 CDI cases and reversed about 61 percent of them. Another SSA study showed that of 6,683 CDI cases terminated at the DDS level in 1980 and 1981, about 50 percent of the cases had been appealed to the ALJ level. As of March 1982 the ALJ's had made decisions on 2,451 cases and reinstated benefits in about 67 percent of them.

As indicated by our March 1981 report, SSA was paying disability benefits to many persons who were not eligible for the program. This has been confirmed by the periodic review efforts to date. While we cannot quantify them, the CDI periodic review is identifying beneficiaries who should never have been placed on the rolls initially, or have medically improved, or have died or returned to work, and otherwise would have gone undiscovered.

However, many of those losing their disability benefits have been on the SSA rolls several years, still have what we would all consider to be severe impairments, and have experienced little or no medical improvement. This raises questions about how and why these people are being terminated, and the fairness of SSA's decisions.

Much of the criticism brought to our attention about the periodic review effort has been directed toward the State agencies, and their procedures for medically developing CDI cases. We found generally that the States were developing and evaluating evidence in conformance with SSA procedures. However, we did find some instances of poor medical development practices as well as some decisions that were not adequately supported. We also questioned the States' practice of gathering and evaluating only evidence that was from the most recent 3 months. We believe, however, that medical development issues are not unique to the CDI effort and are not the primary cause of the high number of cases being terminated.

To address the issue raised about State agency medical development practices, we reviewed 98 CDI cases in the four States we visited. Our purpose in reviewing these cases was to look at the mechanics and timing of the medical development.

Forty-two of the 98 cases we reviewed, or about 43 percent, had resulted in cessations. The 42 cessations we reviewed averaged nearly 127 days from the time the beneficiary was first contacted about the review to the date of the DDS decision. We found no instances where beneficiaries were terminated without being given time to develop and present their medical evidence.

We found that attending physician data is usually requested unless it is not relevant to the impairment, too old, or from a source known to be uncooperative. We found only a few instances where examiners did not request evidence from what we believed was a relevant source. While most sources did respond, we found a significant variation in quality, quantity, and objectivity in their responses.

It is difficult to evaluate the extent to which attending physician data is considered in the States' decisions. Examiners complain that much of the information obtained from treating sources is too old to satisfy SSA's requirements, too subjective, too opinionated, and too sketchy to satisfy evidentiary requirements. Also, treating physicians don't often perform the kinds of tests required by the medical listings. Therefore, while it is clear that some portion of attending physicians' reports are not fully considered, we cannot determine the extent of this nor what impact this has on the final decision. We did see instances where attending physicians said their patients were totally disabled, yet the States discontinued benefits. However, these were invariably cases where the physician submitted little objective evidence to support their conclusions.

One aspect of State agency medical development that we believe needs to be changed is the practice of developing these CDI cases as if they were new claims. SSA has issued no specific development guidance for these cases, but rather has instructed the State agencies to adjudicate these claims in generally the same manner as initial claims. As a result, State agencies are gathering only current evidence—generally no more than 2 or 3 months old—and using this evidence to determine if the beneficiary currently meets SSA's criteria for disability. This practice can result in incomplete information and is one of the major reasons treating sources are not contacted or their information is not considered in the decision. It also explains the high consultative examination purchase rate.

While the need for current evidence is obvious, we also believe there is a need for a historical medical perspective in these CDI cases. Many of these individuals coming under review have been receiving benefits for several years. To base a decision on only the recent examination could give a false reading of that person's condition. This is especially true for those impairments subject to fluctuation or periodic remission, such as mental impairments.

A more significant factor in explaining the number of CDI/Periodic Review terminations is the way the medical evidence is evaluated to determine if eligibility for disability benefits continues.

State agencies use the "sequential evaluation" process to determine if a beneficiary remains eligible. This process is a series of decisions based on medical and vocational evidence. Essentially, the State agency must determine if the beneficiary is working; if the alleged impairment is severe; if the impairment meets or equals the medical listings; or, when the impairment is severe, but does not meet or equal the listings, if it prevents the beneficiary from doing his or her past work or any other work.

SSA, after almost a decade of prompting from the Congress, GAO, and others, has made major changes in the criteria and guidance used in the disability determination process. The criteria have become more explicit in certain areas, and in some areas they have become more stringent.

During the early and mid-1970's, those close to the disability program, especially State DDS administrators, voiced the need for revised medical listings. For example, in response to a March 1976 letter from the chairman of the Subcommittee on Social Security, House Ways and Means Committee, one State administrator wrote, "The listings are outdated and desperately need revision."

There were similar complaints about the need for improved formal guidance on evaluating vocational factors in the sequential evaluation process.

During the mid-1970's, SSA also began to get more explicit about what it meant by a "severe" impairment. This was conveyed in written and oral policy instructions, training programs, and case returns to State agencies from SSA's quality assurance system. The result was an increase in the number of denials for "slight impairment."

All of these changes had a definite impact on tightening up the "adjudicative climate."

The changes to the sequential evaluation process and the adjudicative climate were evolutionary and were not developed to address specifically the CDI/Periodic Review program. Because of the changes, however, many beneficiaries are being terminated. The changes in the medical listings in 1979 have affected some beneficiaries who previously qualified under the old listings, but do not meet the criteria of the revised listings.

Similarly, beneficiaries put on disability because their condition "equaled" the listings now are terminated because of a more narrow application of this concept. In 1975, 44 percent of all awards were based on equaling the medical listings—instances where the impairment was not specifically described in the listings, but was considered equal in severity; or the combination of impairments was medically equal to any that were listed. In 1981 only about 9 percent of all awards were based on equaling the listings. Examiners have told us that beneficiaries allowed in the past with multiple impairments are now being terminated under the CDI effort because their impairments are being evaluated independently rather than looking at the total effect of the impairments.

The formalized vocational grid, now part of the regulations, is also a factor in many terminations. In the mid-1970's many individuals whose impairments did not meet or equal the listings were allowed because of vocational factors, even though there was little or no guidance available at that time on how to evaluate those factors.

When reevaluating beneficiaries previously allowed for vocational factors, State agencies now terminate benefits in many of these cases because of the vocational grid. For example, beneficiaries 49 years old or younger with severe impairments that do not meet or equal the listings cannot be found to be disabled unless they are illiterate or unable to communicate in English. Most of the beneficiaries being terminated under this review effort are age 49 or younger.

In summary, through the CDI/Periodic Review process, SSA is reviewing a group of beneficiaries who were awarded benefits several years ago under a more liberal, less objective evaluation process. These are generally people who were led to believe that they were being granted a lifetime disability pension. Now, with no advanced explanation from SSA about the purpose, process, or possible outcome of the periodic review, they are subjected to a new decision, much the same as if they were applying for disability benefits for the first time. There is no presumptive effect given to the prior findings of disability nor to the years that these individuals have been entitled to payments.

The new decisions are made using a newer, more objective, more stringently interpreted set of evaluation guidelines and are made in a tougher adjudicative climate.

Subjecting everyone to a new decision has a major adverse impact on the group of beneficiaries who were placed on the rolls initially through the appeals process. Because of the historical difference in adjudicative criteria between the State and the administrative law judges, many of these beneficiaries are now being taken off the rolls after reexamination by the same State agency that found them not disabled originally. Since the State's original decision was "not disabled," a new decision by the State would generally be expected to have the same conclusion, particularly in light of the tightened disability determination criteria and adjudicative climate. Many of these individuals may be put back on the rolls after another appeal.

For the reasons discussed above, many beneficiaries whose conditions have not improved or may even have worsened are being told they are no longer disabled and are terminated from SSA's disability rolls. We believe the aspect of "no medical improvement" for a large part of the cessations during the last year accounts for much of the adverse publicity given the CDI/Periodic Review process.

Under SSI's operating guides which have been followed by the States for approximately 4 years, disability is found to have ceased when current evidence shows that the individual does not meet the current definition of disability. SSA's policy states that it is not necessary to determine whether or how much the individual's condition has medically improved since the prior favorable determination.

SSA's policies since 1969 on CDI determinations had been that it was necessary to have documentation supporting an improved medical condition. SSA dropped this policy in May 1976 and until now there have been only a few court decisions on the issue. Those decisions have consistently argued for a return to some form of medical improvement.

The legislative history of the 1980 amendments clearly indicates that the Congress was concerned about the individuals who have medically improved and have remained on the disability rolls. However, it is not clear what the Congress' view was toward those who have not medically improved. Whether the Congress intended that all beneficiaries would be subjected to a new determination, or whether it expected the earlier decisions to afford some presumptive weight, is an issue that we are still reviewing. Recent decisions in the U.S. courts suggest that the "courts believe a degree of" administrative finality or res judicata effect should prevail on these cases. Several class-action suits are pending which presumably will address this issue.

We believe the Congress should state whether cessations are appropriate for those already on the disability rolls who have not medically improved. There are other matters relating to the medical improvement issue that need to be considered also, such as how to deal with those on the rolls as a result of clear erroneous initial awards, and those that, despite no medical improvement, clearly come under a changed eligibility criteria or definition.

That concludes our statement, Mr. Chairman. We will be pleased to answer any questions you may have.

[The prepared statement of Edward A. Densmore follows:]

UNITED STATES GENERAL ACCOUNTING OFFICE
Washington, D.C.

FOR EXPECTED RELEASE
Wednesday, August 18, 1982

STATEMENT OF

EDWARD A. DENSMORE, DEPUTY DIRECTOR

HUMAN RESOURCES DIVISION

BEFORE THE

COMMITTEE ON FINANCE

UNITED STATES SENATE

ON

SOCIAL SECURITY ADMINISTRATION'S PROGRAM FOR REVIEWING THE CONTINUING ELIGIBILITY OF DISABLED PERSONS

SUMMARY OF GAO STATEMENT SUBMITTED TO THE
COMMITTEE ON FINANCE
UNITED STATES SENATE
ON SOCIAL SECURITY ADMINISTRATION'S PROGRAM
FOR REVIEWING THE CONTINUING ELIGIBILITY
OF DISABLED PERSONS

AUGUST 18, 1982

--Based on a nationwide sample case review conducted in 1979, Social Security estimated that as many as 20 percent of the persons on the disability rolls were not disabled. Social Security conducted a follow-up study in 1980 and 1981, and found that about 26 percent of the beneficiaries were ineligible at a cost of about $4 billion annually to the Trust Fund.

--Congress enacted Section 311 of Public Law 96-265, which required Social Security, beginning in January 1982, to review the status of the disabled whose disability has not been determined to be permanent at least once every three years.

--Social Security accelerated its efforts and began reexamining the disability rolls in March 1981. About 451,400 cases were selected for investigation between March 1, 1981, and May 31, 1982. The States made decisions on about 240,000 cases resulting in the termination of benefits in about 106,800 or 44 percent of the cases reviewed.

--Many of the terminated cases, however, have appealed to the administrative law judges. The reversal rate, or those whose benefits were reinstated, was 67 percent according to one study and 61 percent according to another.

--GAO's case review found certain administrative problems in Social Security's decisional process--(1) attending physician data is often not useful to the examiners, and (2) decisions are too frequently based solely on current evidence-- often no more than 2 to 3 months old, and often on "one-shot" consultative medical examinations.

--The most significant contributing factor in the high termination rate is due to the major changes in the criteria and guidance used in the decisional process. The criteria have become more explicit in certain areas, and in some areas more stringent.

--Beneficiaries who were awarded benefits several years ago under a more liberal, less objective evaluation process, are subjected to the newer, more objective, more stringently interpreted set of evaluation guidelines. As a result, many persons are being terminated from the rolls whose medical conditions have not changed or may have become worse.

--GAO believes that the Congress should clarify its intent on whether persons already on the rolls should be subjected to a "new determination", that is, evaluated solely under current criteria, or whether the prior decision should be taken into account and some medical improvement criteria followed.

Mr. Chairman and Members of the Committee, we are pleased to be here today to discuss the Social Security Administration's (SSA's) recent efforts in reexamining the continued eligibility of persons on the disability rolls. These reexaminations, begun in March 1981, are commonly referred to as Continuing Disability Investigations or CDIs.

Because of the concerns expressed to us by several Members of the Congress over the medical conditions of the large number of beneficiaries being terminated from the rolls as part of the CDI effort, in January 1982 we began to review SSA's policies and practices for conducting these investigations. CDIs are performed by the various State Disability Determination Services (DDSs) following guidelines and instructions provided them by SSA. We have met with State officials and examiners in California, New York, Pennsylvania, and Ohio and examined approximately 100 case folders. In addition, we met with several administrative law judges and SSA officials.

We completed our case reviews in May 1982 and provided testimony on May 25, 1982, to the Subcommittee on Oversight of Government Management, Senate Committee on Governmental Affairs. We identified areas that warrant more detailed work and scheduled several assignments to start this year that will probe these selected areas of the CDI program further.

Because audit work has not been performed subsequent to our previous testimony, I will reiterate, with some updated and additional information, our previous testimony.

We have identified a number of issues and problems with the current CDI process that deserve attention by the Congress and SSA. First I would like to explain briefly the evolution of events which brings us [illegible] day's conditions; secondly, present some of our observations to date about the CDI process; and also provide some suggestions for improving the process.

BACKGROUND

In the past, SSA's primary means of identifying beneficiaries who may have medically recovered or regained the ability to work, and assessing their continuing eligibility for disability benefits, was through the "medical reexamination diary process". This process involved establishing a future medical reexamination date (diary) for beneficiaries with certain medical conditions that were believed to have a high potential for medical improvement. When the diary date matured, State agencies were to reevaluate the beneficiaries' medical condition. Investigations were also to be done when it was learned that a beneficiary had returned to work.

We reported to the Congress in March 1981 1/ that SSA had not adequately followed up on disability insurance beneficiaries to verify that they remain disabled. SSA had limited its investigations to a small percentage of beneficiaries, and even beneficiaries who met the criteria for reexamination had not always been investigated. Only about one of every five persons awarded disability was targeted for reexamination. The remainder, about 2.3 million persons, were never reexamined and would very likely

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1/ "More Diligent Followup Needed to Weed Out Ineligible SSA Disability Beneficiaries," HRD-81-48, March 3, 1981.

remain on the rolls unless they returned to work, reached age 65 and converted over to the retirement program, or died.

Based on a nationwide sample case review conducted in 1979, SSA estimated that as many as 20 percent of the persons on the disability rolls did not meet the disability criteria. SSA collected current medical evidence on about 3,000 cases and in some instances visited and interviewed beneficiaries in their homes. Using this evidence, SSA examiners and physicians determined whether or not the individuals were currently disabled. Based upon this sample, we estimated that as many as 584,000 persons were not eligible for benefits costing the Disability Trust Fund over $2 billion annually.

SSA conducted a follow-up study in 1980 and 1981 and reviewed 2,817 randomly selected cases from the 2.8 million beneficiaries that were on the rolls during July, August, or September 1980. In this study nearly all of the cases included one or more consultative examinations. 1/ The findings from this study were consistent with that of the 1979 study, and showed that about 26 percent of the beneficiaries on the rolls during the July/September 1980 period were not disabled. SSA estimated from this study that erroneous disability payments amount to about $4.0 billion annually.

Congressional concern over the high degree of selectivity in designating cases for medical reexamination and other inadequacies in the review procedure led to the enactment of Section 311 of

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1/ In the 1979 study only about one-half of the cases reviewed included consultative examinations. A consultative examination is the purchase of medical evidence in the form of a medical examination or laboratory test.

Public Law 96-265, known as the Social Security Disability Amendments of 1980. This section required that beginning January 1, 1982, SSA review the status of disabled beneficiaries whose disability has not been determined to be permanent at least once every three years. SSA officials estimated that this legislative mandate would require them to perform investigations on approximately 3 million cases over a 3-year period.

Due largely to an increased emphasis on cost-saving measures and to prepare for the massive workload anticipated in 1982, SSA began several projects aimed at improving the continuing disability process. SSA conducted several studies to help profile those beneficiaries with the highest likelihood of being found ineligible for disability benefits. Using these profiles, SSA began reexamining beneficiaries in March 1981 under an accelerated CDI review. 1/

CDI CASE SELECTION AND WORKLOAD

SSA selected about 451,400 cases for investigation between March 1, 1981, and May 31, 1982. The States have completed investigations and made decisions on about 240,000 cases, 2/ resulting in the termination of benefits in about 106,800 or 44 percent of the cases reviewed. This is in addition to the regular

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1/ Beginning January 1, 1982, the review was referred to as the "Periodic Review" because of the legislative mandate.

2/ Another 35,000 cases have been reviewed by the States, but are considered "no decision cases" due to various reasons such as (1) being returned to the SSA district offices for further development of work related issues, (2) being sent to the wrong DDS, (3) individuals are deceased, and/or (4) having had an investigation already done in the last 12 months.

investigations of about 155,000 diaried cases per year that were determined to be subject to medical improvement.

Many of those individuals terminated at the DDS level, however, will appeal and have their benefits reinstated by administrative law judges (ALJs). While there is only a paucity of data to indicate the reversal experience to date, SSA has developed some information. The Office of Hearings and Appeals (OHA) has been tracking CDI cases through the process. OHA's data showed that for the period February through May 1982 the ALJ's adjudicated 16,200 CDI cases and reversed 9,882 cases or 61 percent. Another SSA study showed that of 6,683 CDI cases terminated at the DDS level in 1980 and 1981, about 3,360 or 50 percent of the cases had been appealed to the ALJ level. As of March 1982, the ALJs had made decisions on 2,451 cases and reinstated benefits in 1,647 or 67 percent of them.

During March and April of 1981, cases selected by SSA for investigation involved younger beneficiaries (under age 50) who were initially adjudicated in 1973, 1974, and 1975--years when the quality of decisions was believed to be at its lowest.

A different selection methodology was used beginning in May 1981. Cases were selected each month based on specific profiles using such characteristics as current age, total benefit payments, date of entitlement, numbers and kinds of auxiliary beneficiaries, and age at filing. SSA believed the profile selection technique would result in a more cost-effective use of resources than reviewing random groups of cases.

PERIODIC REVIEW TERMINATIONS--WHY THEY ARE HAPPENING

As indicated by our March 1981 report, SSA was paying disability benefits to many persons who were not eligible for the program. This has been confirmed by the periodic review efforts to date. While we cannot quantify them, the CDI/Periodic Review is identifying beneficiaries who

--should never have been placed on the rolls initially, or

--have medically improved, or

--have died or returned to work, and otherwise would have gone undiscovered.

However, many of those losing their disability benefits have been on the SSA rolls several years, still have what we would all consider to be severe impairments, and have experienced little or no medical improvement. This raises questions about how and why these people are being terminated, and the fairness of SSA's decisions.

We will address these questions by looking at some of the factors causing these terminations (also referred to as cessations) including:

--State agency medical development practices, and

--the changed adjudication process and climate.

State Agency Medical Development Practices

Much of the criticism brought to our attention about the periodic review effort has been directed toward the State agencies, and their procedures for medically developing CDI cases. Specifically, concern has been expressed that State agencies are

- --terminating benefits without giving individuals adequate time to present medical evidence,
- --not obtaining or considering relevant information from treating physicians, and
- --overrelying on purchased consultative examinations which are sometimes too brief and possibly biased.

We did find some instances of poor medical development practices, as well as some decisions that were not adequately supported. We also question the State agencies' usual practice of gathering and evaluating only evidence that is from the most recent three months. We believe, however, that medical development issues are not unique to the CDI effort and are not the primary cause of the high number of cases being terminated.

Results of case review

To address the issue raised about State agency medical development practices, we reviewed 98 CDI cases in the 4 States we visited. Most of the cases were selected--either directly by us, or by State agency personnel monitored by us--as the State agency quality assurance units completed their technical review. This total also contained some cases (6) that had received a hearing before an administrative law judge. Our purpose in reviewing these cases was to look at the mechanics and timing of the medical development.

Forty-two of the 98 cases we reviewed, or about 43 percent, had resulted in cessations. Because of the small size of our sample, and the timing of our selection, we cannot project the results of our sample to what has happened in the CDI/Periodic Review effort since March 1981. The table below presents some of the statistical information about the cases we reviewed.

	Cessations	Continuances	Total
Number of cases	42	56	98
Average age of beneficiary	43	45	44
Average years on disability	7	9	8
Average case processing time 1/ (in days)	127	83	102
Percent of cases where claimants' physicians were contacted	69	74	71
Percent of contacts responding to DDS	90	81	85
Percent of cases with consultative exam ordered	86	54	67

1/ We counted from the date beneficiary was first contacted concerning the review (either by mail or phone) to the date the DDS physician signed the notice of decision.

The 42 cessations we reviewed averaged nearly 127 days from the time the beneficiary was first contacted about the review to the date of the DDS decision. This includes the 10 or more days allowed a beneficiary after being notified of the decision to submit any additional evidence. The shortest processing time we found for a terminated case was 34 days, the longest was 368. We found no instances where beneficiaries were terminated without being given time to develop and present their medical evidence.

We found that attending physician data is usually requested unless it is not relevant to the impairment, too old, or from a source known to be uncooperative. We found only a few instances where examiners did not request evidence from what we felt was a relevant source. While most sources did respond, we found a significant variation in quality, quantity, and objectivity in their responses.

It is difficult to evaluate the extent to which attending physician data is considered in the States' decisions. Examiners complain that much of the information received from treating sources is too old to satisfy SSA's requirements, too subjective, too opinionated, and too sketchy to satisfy evidentiary requirements. Also, treating physicians often don't perform the kinds of tests required by the medical listings. Therefore, while it is clear that some portion of attending physicians' reports are not fully considered, we cannot determine the extent of this nor what impact this has on the final decision. We did see instances where attending physicians said their patients were totally disabled, yet the States discontinued benefits. However, these were invariably cases where the physicians submitted little objective evidence to support their conclusions.

There has also been much concern expressed about the use--or overuse--of consultative examinatons in connection with the CDI effort. The 1981 consultative examination purchase rate in CDI cases varied in the four States visited. We estimate it was 62 percent in Pennsylvania, 59 percent in Ohio, 58 percent in California, and 39 percent in New York.

Examiners say CDI's generally require consultative examinations more often than other claims because many long-term disabled people haven't been to physicians recently. Ohio, for example, ordered examinations for only 30 percent of its entire caseload, but nearly 60 percent for CDI's. During this limited study, we did not attempt to evaluate the appropriateness of the consultative exam purchase rate, or the quality of the exams purchased. We do, however, plan to look at these and other issues pertaining to consultative examinations in the near future.

CDI cases need special development

One aspect of State agency medical development that we believe needs to be changed is the practice of developing these CDI cases as if they were new claims. SSA has issued no specific development guidance for these cases, but rather has instructed the State agencies to adjudicate these claims in generally the same manner as initial claims. As a result, State agencies are gathering only current evidence--generally no more than 2 or 3 months old--and using this evidence to determine if the beneficiary currently meets SSA's criteria for disability. This practice can result in incomplete information and is one of the major reasons treating sources are not contacted or their information is not considered in the decision. It also helps explain the high consultative examination purchase rate.

While the need for current evidence is obvious, we also believe there is a need for a historical medical perspective in these CDI cases. Many of these individuals coming under review have been receiving benefits for several years. To base a decision on only the recent examinaton--often a purchased consultative examination--could give a false reading of that person's condition. This is especially true for those impairments subject to fluctuation or periodic remission, such as mental impairments.

For example:

> A 49 year old beneficiary in Pennsylvania was awarded disability insurance benefits in 1966 for schizophrenia. As part of the CDI/Periodic Review, the State agency tentatively determined in March 1982 that his disability had ceased. This decision was based soley on a consultative examination report that found him "fairly alert and responsive with schizophrenia controlled by medication". Following a due process procedure, however, the State agency reversed its decision in April 1982 because of information submitted by the beneficiary's treating physician. This report showed a history of repeated hospitalizations since 1950, emotional swings, and withdrawn and anti-social behavior.

Another tie between the initial claims process and the CDI efforts that might need change is the processing time goal. One measure of examiner performance in both initial claims and CDI cases is the percent of cases pending over 70 calendar days. While some examiners in the 4 states visited said they felt no undue pressure to move CDI cases, others said they are constantly aware of the time goal pressures. They felt it was unrealistic to be expected to develop these CDI cases in 70 days. CDI cases are often more difficult to develop than initial claims, and are more time consuming since they generally require more use of consultative exams.

We plan to evaluate this issue further to determine if it is causing examiners to rush their decisions.

The Adjudication Process and Climate

A more significant factor in explaining the number of CDI/Periodic Review terminations is the way the medical evidence is evaluated to determine if eligibility for disability benefits continues. State agencies use the "sequential evaluation" process to determine if a beneficiary remains eligible. This process is a series of decisions based on medical and vocational evidence. Essentially, the State agency must determine if the beneficiary is working; if the alleged impairment is severe; if the impairment meets or equals the medical listings 1/; or, when the impairment is severe, but does not meet or equal the listings, if it prevents the beneficiary from doing his/her past work or any other work.

Changes in the Evaluation Process

SSA--after almost a decade of prompting from the Congress, GAO, and others--has made major changes in the criteria and guidance used in the disability determination process. The criteria have become more explicit in certain areas, and in some areas they have become more stringent.

During the early and mid-1970s, those close to the disability program, especially State DDS administrators, voiced the need for revised medical listings. For example, in response to a March 1976 letter from the Chairman of the Subcommittee on Social Security, House Ways and Means Committee, one State administrator wrote, "The listings are outdated, and desperately need revision." Another said:

> "...the listings are about 10 years out of date . . . for example listing 404, on myocardial infarction, is considered in error. A large majority of persons who have myrocardial infarctions, and survive, do return to work. Therefore, we may be allowing claims in which return to work is more than reasonable, in light of current medical practice..."

1/Medical evidence by itself is sufficient to establish that a person is disabled where it establishes the presence of an impairment included in the "Listing of Impairments" or an impairment(s) medically equivalent to a listed impairment(s).

The medical listings were finally revised in 1979.

There were similar complaints about the need for improved, formal guidelines on evaluating vocational factors in the sequential evaluation process. In a 1978 Subcommittee report, Members of the Subcommittee on Social Security stated that they had

> "...for years urged the promulgation of more definite regulatory guidelines which would promote uniformity in decisionmaking and provide for enhanced administrative control of the program in this area. These proposed regulations spell out through a grid mechanism the weights to be given to the nonmedical factors..."

The vocational grid became effective in 1979.

During the mid-1970s, SSA also began to get more explicit about what it meant by a "severe" impairment. This was conveyed in written and oral policy instructions, training programs, and case returns to State agencies from SSA's quality assurance system. The result was an increase in the number of denials for "slight impairments".

All of these changes had a definite impact on tightening up the "adjudicative climate". In response to a 1978 survey by the Subcommittee on Social Security, one State administrator said,

> "...I believe the primary reason for the recent conservative approach to disability evaluation is a direct result of the activities of the Subcommittee on Social Security, the General Accounting Office, and others involved in evaluating the effectiveness of the program. The Administration has apparently carefully considered all of the comments, inquiries, opinions, etc., and concluded that a 'tightening up' is desired. This view may be somewhat of an over simplification; but in the real world it is quite likely the root cause of the recent trends. In summary, I believe the 'adjudicative climate' has changed."

Impact of Changes on the CDI Beneficiaries

The changes to the sequential evaluation process and the adjudicative climate were evolutionary and were not developed to address specifically the CDI/Periodic Review program. Because of the changes, however, many beneficiaries are being terminated. The changes in the medical listings in 1979 have affected some beneficiaries who previously qualified under the old listings, but do not meet the criteria of the revised listings. For example:

> A 51 year old beneficiary in New York was awarded disability benefits in 1975 following a myocaridial infarction (heart attack). At that time, the medical listings only required evidence showing that the infarction occurred, and that the claimant had chest discomfort. The revised medical listings for heart impairments now require specific exercise test results or specific readings from a resting electrocardiogram (EKG). While the beneficiary's resting EKG readings in both 1974 and 1982 show similar abnormalities and he continues to suffer from angina (chest pain), his benefits were terminated because the EKG readings do not meet the requirements of the new listings.

Similarily, beneficiaries put on disability because their condition "equaled" the listings are now being terminated because of a more narrow application of this concept. In 1975, 44 percent of all awards were based on equaling the medical listings--instances where the impairment was not specifically described in the listings, but was considered equal in severity; or the combination of impairments was medically equal to any that were listed. In 1981, only about 9 percent of all awards were based on equaling the listings. Examiners have told us that beneficiaries allowed in the past with multiple impairments are now being terminated under the CDI effort because their impairments are being evaluated independently rather than looking at the total effect of the impairments. For example:

> A 50 year old beneficiary in Ohio suffered from hypertension, diabetes, and depression. Although none of these impairments met the specific listing, the claimant was awarded benefits in 1971 when their combined effect was considered. As part of the CDI review, the State agency obtained evidence that contained essentially the same findings as that from 1971. However, the State agency now considered the impairments individually and terminated benefits because none met the specific listings.

The formalized vocational grid, now part of the regulations is also a factor in many terminations. In the mid-1970s many individuals whose impairments did not meet or equal the listings were allowed because of vocational factors (age, education, prior work experience)--even though there was little or no guidance available at that time on how to evaluate those factors. When re-evaluating beneficiaries previously allowed for vocational factors, State agencies now terminate benefits in many of these cases because of the vocational grid. For example, beneficiaries 49 years old or younger with severe impairments that do not meet or equal the listings cannot be found to be disabled unless they are illiterate or unable to communicate in English. Most of the beneficiaries being terminated under this review effort are age 49 or younger.

A New Decision

In summary, through the CDI/Periodic Review process, SSA is reviewing a group of beneficiaries who were awarded benefits several years ago under a more liberal, less objective evaluation process. These are generally people who were led to believe that they were being granted a lifetime disability pension. Now, with no advanced explanation from SSA about the purpose, process, or possible outcome of the Periodic Review--they are subjected to a new decision, much the same as if they were applying for disability benefits for the first time. There is no presumptive effect given to the prior findings of disability, nor to the years that these individuals have been entitled to payments.

The new decisions are made using a newer, more objective, more stringently interpreted set of evaluation guidelines; and are made in a tougher "adjudicative climate." At the same time, these decisions are subject to the same inherent weaknesses that have always plagued the SSA disability determination process--subjectively, and medical development of questionable quality and completeness.

Subjecting everyone to a new decision has a major adverse impact on the group of beneficiaries who were placed on the rolls initially through the appeals process. Because of the historical differences in adjudicative criteria between the State and the administrative law judges (ALJs), many of these beneficiaries are now being taken off the rolls after reexamination by the same State agency that found them not disabled originally. Since the State's original decision was "not disabled," a new decision by the State would generally be expected to have the same conclusion, particularly in light of the tightened disability determination criteria and adjudicative climate. Many of these individuals may be put back on the rolls after another appeal. 1/ We do not know how many cases are affected by this "merry-go-round" review, but the number could be quite large.

MEDICAL IMPROVEMENT ISSUE NEEDS TO BE ADDRESSED

For the reasons discussed above, many beneficiaries whose conditions have not improved, or may even have worsened, are being told they are "no longer disabled," and are terminated from SSA's disability rolls. We believe the aspect of "no medical improvement" for a large percentage of the cessations during the last year accounts for much of the adverse publicity given the CDI/Periodic Review process. This is not a new issue, but perhaps has been exacerbated by the large number of "non-diaried" cases examined by SSA during the last year.

During our limited case review, we did not attempt to quantify the number of cessations where there was no apparent medical improvement. However, a recent SSA study may provide some insight into this question. The study evaluated over 21,000 disability cases, and discontinued benefits in about 7,000 (33 percent). These cases were reviewed by SSA examiners and physicians for changes in the severity of the individual's impairment. Of the 7,000 cases where benefits were terminated, only 51 percent were

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1/ A recently completed study by SSA of over 3,600 decisions by ALJs highlighted clear differences in adjudicative criteria between the ALJs and the States as a major reason for the high number of decisions by ALJs to award benefits. For example, the ALJs awarded benefits in 64 percent of the 3,600 cases, whereas SSA's Office of Assessment, using State agency criteria, would have awarded benefits in only 13 percent. The study also highlighted the significant effect of a face-to-face meeting with the claimant.

determined to have medically improved. In 35 percent of the cases, benefits were ceased even though the severity of the impairments was judged to be the same as or worse than when benefits were initially awarded.

Under SSA's operating guides which have been followed by the States for approximately 4 years, disability is found to have ceased when current evidence shows that the individual does not meet the current definition of disability. SSA's policy states that it is not necessary to determine whether or how much the individuals' condition has medically improved since the prior favorable determination.

The possible need for legislation on the medical improvement issue was addressed by a 1976 staff report of the Subcommittee on Social Security, House Committee on Ways and Means, entitled "Disability Insurance--Legislative Issue Paper." SSA's policies since 1969 on CDI terminations had been that it was necessary to have documentation supporting an improved medical condition. The staff report pointed out that

> Revitalization of the CDI program can be carried out administratively, although if it is the subcommittee conclusion that the medical improvement requirement criteria should be altered, this may have to be done by legislation.

SSA dropped its former policy in May 1976 and until now there have been only a few court decisions on the issue. Those decisions have consistently argued for a return to some form of medical improvement.

The legislative history of the 1980 Amendments clearly indicates that the Congress was concerned about the individuals who have medically improved and remained on the disability rolls. However, it is not clear what the Congress' view was toward those who have not medically improved. Whether the Congress intended that all beneficiaries would be subjected to a "new determination," or whether it is expected the earlier decisions to afford some presumptive weight, is an issue that we are still reviewing. Recent decisions in the U.S. Courts suggest that the Courts believe a degree of "administrative finality" or res judicata effect should prevail on these cases. Several class-action suits are pending which presumably will address this issue.

We believe the Congress should state whether cessations are appropriate for those already on the disability rolls who have not medically improved. There are other matters relating to the medical improvement issue that need to be considered also, such as how to deal with those on the rolls as a result of clear erroneous initial awards, and those that, despite no medical improvement, clearly come under a changed eligibility criteria or definition. We plan to work with this Committee and other Members of the Congress in developing these matters further.

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We plan to continue reviewing several of the other issues discussed, and as this work progresses we will consider what actions SSA should take to improve the disability determination process and, specifically, the Periodic Review.

On July 14, 1982, we transmitted our previous testimony to the Secretary, Department of Health and Human Services, and recommended that the Commissioner of Social Security take the following actions.

--Notify all disability beneficiaries and explain to them the purposes of the Periodic Review, and the importance of their providing complete and current medical evidence. If these reviews remain "new determinations" with little consideration given to the prior determination, this aspect should be fully explained to the beneficiaries.

--Issue policy guidance to the State agencies emphasizing the need for obtaining a full medical history in all Periodic Review cases. The medical history should cover the period from the initial disability determination and include medical information used in the initial determination.

--Establish a processing time goal for managing the Periodic Review caseload that is commensurate with thorough development of medical evidence.

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That concludes our statement. We shall be pleased to respond to any questions you or other members of the Committee may have.

Senator ARMSTRONG. Mr. Densmore, we are very grateful for your statement, which is very thoughtful and identifies some issues which we want to address at an early date.

Senator Mitchell, do you have questions?

Senator MITCHELL. No, I don't.

Senator ARMSTRONG. I am going to withhold my own questions for the time being as well. The constraints under which we operate this afternoon are not the time of the Senators or the Chair, but I am told reliably that the last flight to St. Paul, Minn. is at 5:45 this afternoon; so, we are going to try to move quite rapidly through the balance of the scheduled testimony this afternoon in order to get our panelists on, some of whom have some commitments that they need to meet.

Senator Heinz, I was just saying that I was going to hold my questions for the GAO in order to get our two panels on and let them meet their travel schedule.

Senator HEINZ. So will I.

Senator ARMSTRONG. Thank you very much.

[The following questions and answers were subsequently supplied:]

QUESTIONS FROM SENATOR WILLIAM ARMSTRONG

1. According to your statement, 44 percent of the CDI cases reviewed resulted in benefit terminations. That's a rate which is more than twice SSA's initial estimate of the percent of persons on the rolls but not disabled. What accounts for the higher rate of CDI terminations? Is it because CDIs are targeted to cases more likely to be terminated? Or is it the result of changes in the criteria used?

SSA'S initial estimate, which was based on a nationwide sample case review, showed that 20 percent of the 2.9 million title II primary beneficiaries did not meet the eligibility criteria for disability. The criteria used to make this determination was the same criteria that is currently used to adjudicate cases. Those judged ineligible tended to be younger beneficiaries who were originally put on the rolls in the error-prone years of the mid-1970s. A later study--the CDI Redesign Study--focused on disabled workers under age 62 and those put on the rolls between 1970 and 1978. The estimated cessation rate in this study was 33 percent.

Based on the results of these two studies, SSA "targeted" those to be reviewed under the Accelerated/ Periodic Review effort. Thus, the resulting 44 percent cessation rate comes from a much narrower group of disability beneficiaries--a group with a higher probability for cessation.

The following factors that we mentioned in our testimony are also contributing to the cessation rate:

--giving beneficiaries "new decisions" and using more stringent criteria than that used to allow them initially,
--subjectivity in the process and the influence of a tougher "adjudicative climate",
--erroneous initial decisions, and
--reevaluations by the State agencies of awards by administrative law judges that may not have been erroneous, but were not acceptable to the State examiners.

2. If the Congress decides that a medical improvement standard should be adopted, would it be possible to conduct reexaminations (CDI's) based on the disability standards in use when an individual's initial eligibility determination was made. If not, why?

We believe it would be very difficult and cumbersome to require a judgement of disablity based on previous years' standards and criteria. While this would be possible, it would require disability examiners to frequently apply different approaches and policies to their cases depending on the dates of initial awards. In many cases, the medical criteria previously used did not specifically address various laboratory test results, and it would be confusing to examiners to have current medical evidence with little or no applicability to previous years' standards. The process would also be confusing in situations where the claimant was originally judged disabled for "meeting" the medical listings alone, but now may have improved to the point of not meeting the previous medical listings; yet the possibility remains that the individual would have been judged disabled previously when vocational considerations were made.

The question apparently makes the assumption that language such as contained in S.2776 and some other bills pertaining to medical improvement would be adopted. We believe the Congress could adopt other medical improvement criteria which would not require an evaluation based on the disability standards in effect in previous years.

3. Has the increased backlog of CDI cases resulted in perfunctory reviews, forced state adjudicators to spend less time on cases or otherwise resulted in poor case development?

The 42 cessation cases we reviewed averaged nearly 127 days from the time the beneficiary was first contacted about the reexamination to the date of the DDS decision. The shortest processing time we found was 34 days, the longest 368. We found no instances where beneficiaries were terminated without being given time to develop and present their medical evidence. We found that attending physician data is usually requested unless it is not relevant to the impairment, too old, or from a source known to be uncooperative. In only a few instances the examiners did not request medical evidence from what we felt was a relevant source. While most sources did respond, we found significant variations in quality, quantity, and objectivity in their responses. We also contacted the DDS administrators in six States and were told that, while backlogs have significantly increased, the quality of the decisions and the time to develop the cases have not been compromised.

4. In your testimony you state that you found "no instances where beneficiaries were terminated without being given time to develop and present their medical evidence", and "only a few instances where examiners did not request evidence from what we felt was a relevant source." In light of this, do you have an explanation for why the adequacy of medical evidence development is so frequently criticized?

There are several possible reasons why criticisms are directed at medical evidence development. Perhaps the biggest reason is that it's the most visable and vital part of the disability adjudication process. Individuals who disagree with the denial or cessation decisions, particularly those whose claims have been denied, logically criticize the examiners' conclusions that the medical evidence does not support a finding of disability.

There are also many cases where it appears that State agencies are dismissing the evidence provided by treating sources, especially when the treating physician renders an opinion that the beneficiary is "totally disabled" without supporting the claim with objective evidence. Similarly, there are cases where the State agencies request information from treating sources but either because the evidence is too old, or lacks objective data to satisfy SSA's criteria, the treating source evidence cannot be used in the disability decision. It is difficult for the beneficiaries, the medical community, and the general public to understand how this can happen. Without a thorough understanding of SSA's disability criteria, an often reached conclusion is "poor medical development."

5. Do you see instances in which Congressional intent or the actual statute is being violated?

Based on our work to date, we are not aware that Congressional intent or the statute is being violated. However, as we indicated in our statement, we are not sure what Congressional intent was regarding individuals who have not medically improved or recovered from their medical problems.

6. Have the changes that were made in recent years in the regulations pertaining to the so-called "medical listings" and "vocational factors" caused an unintended tightening of the program?

The changes have resulted in a tightening of the program's eligibility requirements. However, the Social Security Administration has stated that these changes made to the adjudicative criteria were not designed to "tighten" the eligibility requirements, but were made principally to attain more uniformity and objectivity in the decisional process. The Congress and GAO have historically recommended to SSA the need for more uniformity and objectivity. As a result, in 1978 SSA updated its medical listings, which had become antiquated, to reflect technological and medical science advances. Also in 1978, SSA issued a decisional grid to assess more objectively an individual's vocational characteristics.

Because of these actions the criteria for deciding disability cases tended to be more restrictive. Consequently, with the new criteria in place, it became more difficult for initial claimants and for those individuals being reexamined to qualify for disability.

7. Do you think legislation is needed to bring about more uniformity between the State agency and ALJ decisions?

There is no question that administrative law judges (ALJs) and State agencies are making different decisions, and that many of these differences are due to differences in their respective adjudicative policies and practices. More uniformity is needed, but whether legislation is necessary to accomplish it, we don't know.

SSA highlighted some of these differences in it's January 1982 report to the Congress ("The Bellman Report") on the implementation of Section 304(g) of Public Law 96-265. In its report, SSA also discussed administrative actions it planned to take to bring about greater uniformity in decisions. These actions included better training for ALJs and requiring that adjudicative standards and guidance governing State and ALJ decisionmaking be essentially the same. Specfically, SSA stated in the report that it intends to expand the use of Program Policy Statements (which become Social Security Rulings) to address policy and adjudicatory areas which it believes are the most troublesome and currently resulting in inconsistent applications.

There has been some Congressional concern expressed over whether such planned policy announcements should go through the general rulemaking procedures for the agency which would require public review and comment before issuance. We are not prepared at this time to comment on SSA's specific plans, the manner in which they should be carried out, nor their possible results.

QUESTIONS FROM SENATOR JOHN HEINZ

1. I understand that when an individual first applies for social security disability benefits, the individual has the burden of proving that he or she is disabled within the meaning of the law. What happens after an individual has met this stringent definition of disability, is awarded benefits and is then scheduled for a periodic review? Does SSA have to prove that the individual's condition has changed and that the individual is no longer disabled? Or does the individual have to prove he or she is disabled all over again? The way the continuing disability investigations are administered, is this redetermination more like a periodic reapplication for benefits than a periodic review?

The initial burden of proof in disability cases is on the claimants. This burden consists of the claimants having to submit evidence to support their claim, and that they show the inability to return to their former employment. It is generally recognized that SSA has the burden of proving that alternate substantial gainful employment exists for the claimants.

While both parties do have responsibilities in periodic review cases, it is not clear where the responsibilities end, nor exactly what must be proven. SSA generally takes the position that where evidence shows that the individual is not currently disabled, a finding of cessation is appropriate. The following excerpt from Social Security Ruling 81-6 states this position.

> "Where the evidence obtained at the time of a continuing disability investigation (CDI) establishes that the individual is not currently disabled or blind, a finding of cessation is appropriate. It will not be necessary to determine whether or how much the individual's condition has medically improved since the prior favorable determination"

As we indicated in our testimony, we don't know whether this policy is consistent with Congressional intent for the periodic reviews. We think the Congress needs to clarify this issue.

Presently, SSA's instructions for reviewing these periodic review cases treats them as if they were new applications, or periodic reapplications as you referred to them. Whether such treatment is appropriate, or satisfactory to the Congress, we don't know. We are still studying this issue, and included in our study are the many decisions in the U.S. Courts relating to this issue. Several class-action suits are pending around the country which relate to this issue as well.

2. In March 1981, the GAO issued a report which stated that as many as 20 percent of the people on the disability rolls may not be disabled. How did GAO reach that 20 percent estimate? What kind of evaluation did GAO perform of the people on the rolls?

For its March 1981 report, GAO did not perform any evaluations of individuals on the disability rolls. As stated in the report, the 20 percent estimate was based on a comprehensive study conducted by the Social Security Administration. The study--the Disability Insurance Pilot--randomly selected 3,000 sample cases, collected medical evidence including conducting consultative medical examinations in about one-half of the cases, used experienced examiners, visited and interviewed many beneficiaries in their homes, and had all of the cases reviewed by SSA physicians.

Senator ARMSTRONG. May I now call the panel consisting of Dr. Cohen, Dr. Talbott, and Mr. Barry Stern of the Pennsylvania Department of Labor. For the reasons that I have already expressed, I hope that the witnesses will be able to summarize their statements and that they will appreciate the problem of time that we are facing. I suspect they probably have travel schedules to meet as well.

We are very pleased to welcome these distinguished panelists. Dr. Cohen, if you would begin, we are very eager to hear your testimony.

STATEMENT OF DR. WILBUR J. COHEN, CHAIRMAN, SAVE OUR SECURITY, WASHINGTON, D.C., FORMER SECRETARY, DEPARTMENT OF HEALTH, EDUCATION AND WELFARE

Dr. COHEN. I would suggest, Mr. Chairman, that you put my statement in the record. I won't repeat most of the things that have already been said but will bring up several points that Senators have asked questions about.

Senator ARMSTRONG. That would be very useful, and we would be delighted to put your statement in full in the record.

Dr. COHEN. And I would like to put the names of the organizations that I represent, which are practically every disabled and handicapped organization in the United States. I represent the SOS here at this meeting.

Senator ARMSTRONG. That would be very useful, as well.

Dr. COHEN. May I just say, as a matter of personal privilege, I think as some members of the committee know, that in addition to being Secretary of HEW in 1968 I did draft the original 1952 legislation on the disability freeze for Congressman Kean of New Jersey, and I drafted the disability legislation in 1956 for Senator George, who was then Chairman of the Senate Finance Committee. So my association with the disability program commences right with the beginning of the program, and I have had a long history of association with it.

I only say that because I am absolutely dismayed at the way the present program has been administered this year, because it is so inconsistent with the whole philosophy and background of the Social Security Administration over the previous 45 years.

As you know, there is a study put out by the University of Michigan which showed that the Social Security Administration ranked No. 1 in public reaction to the degree of service that people felt they got from the Social Security offices. And I believe, along with statments that members of the committee including Senator Heinz have made here, that what has happened in the administration of this program in this last year or so has shaken the foundations of public support for the administrative competence of the Social Security Administration.

My view is that what happened is that the Social Security Administration decided to implement the 1980 amendments too fast and without adequate preparation. And while I recognized in the hearing today that they made certain changes, I think that is a frank admission of the fact that they were absolutely unprepared in planning for it.

When I had the responsibility for the implementation of the medicare program in 1965, we didn't touch a single development of that without 11 months of preparation, and I always felt that I didn't have enough time even with those 11 months. But to have implemented the 1980 legislation so quickly without adequate staff, without training of people in the State agencies, without changing the determination forms—as has been indicated here—and doing a lot of other things, I think was a major matter of mismanagement decision. I think we are paying a very, very big price for that.

While I strongly suggest that much can be done by administrative change, I believe a number of changes can only be accomplished by legislation; but I do believe, in connection with what Senator Dole said, I would like to see this committee ask Secretary Schweiker and Commissioner Svahn to put a 30-, 60-, or 90-day moratorium on what is happening in these CDI's. I think we just simply have to stop these suicides and not only the confusion but the absolute anxiety.

I cannot tell you the people who have come to me concerning the disability program knowing that I was a former Secretary. And though I have no opportunity anymore to have any influence on administration, I am absolutely aghast at the anxiety that this has stimulated among disabled people.

I would just like to say, in addition, I am sorry Senator Durenberger isn't here, because I believe the national economy test that is in the law ought to be repealed. The national economy test says that because there is some person in Utah who might be able to dig potatoes in Maine, that therefore that person in Utah is not disabled because he can substantially engage in gainful activity in Maine, or because he is a jewelry worker in St. Paul and there is a job in the jewelry industry in Rhode Island, that that person can work and therefore is not eligible for the benefits.

I want to say I was a party of putting the national economy test in the law, so I am criticizing myself—I am not criticizing Congress—but on the basis of a rather extensive study of which I was a member by appointment of Speaker O'Neill of the National Commission on Social Security, there is a whole chapter in its report on the disability programs which I don't think anybody has read—unfortunately. I would urge the staff of the committee to do that, because in addition we recommend various changes in the disability program including repeal of the national economy test.

The other thing that I think is necessary is absolutely to take social security out of the unified budget. I know Senator Heinz, and I know Mr. Gradison in the House, and I think 70 Members of the House in both political parties are saying take social security out of the unified budget, because you cannot persuade people—at least, I have not, and I probably have made 25 speeches on social security in the last 2 or 3 months—persuade people that these various things that are happening are not being done for budgetary purposes. And I think that what is happening as a result of all this is an undermining of people's confidence and integrity in the whole social security system.

All of the amendments that have been discussed by Senator Metzenbaum, Senator Riegle, Senator Cohen, and Senator Levin, in my statement I support them absolutely and enthusiastically; but I want to enter two more that have not been discussed.

We are opposed to legislation closing the record of the claimant at the reconsideration level. This is inconsistent with the nature and development of many degenerative disabilities which become more serious as time passes. Now, the reason I mention that, that is a provision in the House bill that Mr. Pickle introduced, and I want to put you on notice that our organization is very critical of several of the provisions in the Pickle bill, just like the administration is on other provisions; and I think if the Pickle bill came over here today it would start a first-class controversy about that particular provision.

Another point: We do not support legislation to make the program operations manual system, which has the acronym POMS, binding on the administrative law judges.

Now, in answer to what Senator Chafee said, the idea of having some unified way of getting everybody from the Social Security, the State agency, the reconsideration, the ALJ, all to agree on the same standard and the same application, I have to say I think is virtually impossible. It's a nice idea if you say "everybody ought to apply the same standards," but in our opinion to try to do this is a denial of due process by prohibiting the administrative law judge from basing his decision on a face-to-face review of the actual evidence. He is the one who can see and talk with the claimant, cross-examine him, and to make a decision on the basis of all the evidence that the claimant produces at that time.

So we strongly support the ALJ's independent status as a countermeasure to administrative and bureaucratic misjudgment of individual cases, based primarily upon a paper review.

I am just as much concerned as I was when I was in charge of this program, Senator Chafee, of the very large volume of administrative law judge changes in the decisions; but I have come to the conclusion, reluctantly, that there is no way to do that in disability cases that doesn't take into account that the administrative law judge is the one person who can see that person, get all the evidence, and in which there is a lawyer present to defend his or her rights. Many times in the other parts of the case, the person has no representation. It is at the administrative law judge level that it does that.

It is true, if you read *Hopkins* v. *Cohen* in the Supreme Court—I was the Cohen, not Senator Cohen—in which I was sued, in which we give the lawyers 25 percent of the amount that is won. But I think that unless you preserve the administrative law judges' integrity and are willing to use the lawyers, you are not really protecting the claimants under this program.

I want to end with just one other point. The organization that I represent, SOS, which includes about 100 organizations in this country, we have within our own organization not only 2 former Secretaries of HEW—myself and Secretary Fleming, who was in the Eisenhower administration—we have 3 former Commissioners of Social Security, we have 2 other Commissioners of Aging, and many other former administrators of various aspects of the program who are very conversant with the problems, issues, alternatives, and options in the disability program. We have members closely familiar with various disablements such as blindness, multiple sclerosis, mental retardation, and with the legal rights and responsibilities of claimants, the appeals procedure, and the program.

Now, we have tried to offer our services both at the House level, at the Senate level, and to the administration, because we believe our experience and our competence would assist in working out a satisfactory resolution to this widespread confusion, frustration, and dissatisfaction caused by the 1980 amendment and what we consider their precipitous and ill-prepared administration.

I want to repeat that offer, Senator, in light of what Senator Dole said. I think in our organization, and as well what you will hear in the State organizations, we have ideas about how this can be resolved. But I think that time is of the essence, because there are people who are being very adversely affected. We would like to see some resolution of this as promptly as possible.

Senator ARMSTRONG. Thank you, Dr. Cohen. We appreciate your statement, and we appreciate your offer of help.

[The prepared statement of Wilbur J. Cohen follows:]

NEEDED LEGISLATION IN THE DISABILITY INSURANCE PROVISIONS OF THE SOCIAL SECURITY PROGRAM

Statement by Wilbur J. Cohen
Chairman, S.O.S., The Coalition to Save Social Security
Before the Senate Committee on Finance
August 18, 1982

Summary

S.O.S. strongly advocates:

1. Support for a fair and humane administration of continuing disability investigations (CDI) at a rate which is based upon increased staffing, assurance of adequate medical, vocational, and psychological information in the claimant's file, and adequate information and assistance to individuals before any termination of benefits.

2. Support for legislation which requires the Social Security Administration to have evidence of medical improvement of a disabled recipient before notice of termination of benefits, or a finding to the claimant that the original decision granting benefits was clearly erroneous and the reason therefore.

3. Support for legislation modifying the 1980 legislation which immediately will slow down the CDI process to assure that the reviews will be accomplished accurately and fairly in an administratively responsible manner, consistent with the availability of the necessary State and regional personnel and due process. We support additional personnel at all levels to accomplish this objective.

4. Support for legislation which will permit claimants who appeal their termination to continue to receive benefits during the appeals process through the administrative law judge level.

5. Reestablishment of an independent Social Security Board to administer the disability and entire Social Security Program so it will not become involved in what the contributors and beneficiaries think are "political" implications.

6. We are opposed to legislation closing the record of the claimant at the "reconsideration" level. This is inconsistent with the nature and development of many degenerative disabilities which become more serious as time passes.

7. We do not support legislation to make the Program Operations Manual (POMS) binding on the administrative law judges. In our opinion, this is a denial of due process by prohibiting the judge from basing his decision on a face-to-face review of the actual evidence before him and cross examination of the claimant at the time he makes his decision. We strongly support the ALJ's independent status as the countermeasure to administrative and bureaucratic misjudgment of individual cases based primarily upon a paper review.

Conclusion

We have within our organization not only two former Secretary's of HEW, three former Commissioners of Social Security, and two other Commissioners of Aging, but many former administrators of various aspects of the program who are very conversant with the problems, issues, alternatives, and options in the disability program. We have members closely familiar with various disablements such as blindness, multiple sclerosis, mental retardation, etc., and with the legal rights and responsibilities of claimants, the appeals procedures of the program. We offer our experience and competences as services to the Committees of Congress and their staff to assist in working out a satisfactory resolution to the widespread confusion, frustration, and dissatisfaction caused by the 1980 amendments and their precipitate and ill-prepared administration. We hope the Congress will provide leadership in restoring the program to a sound, compassionate and fair administration.

SAVE OUR SECURITY

14-Point Program To Protect Social Security

1. BORROWING FROM HEALTH INSURANCE -- To meet the present short-range crunch, the Old Age and Survivors' Insurance Trust Fund should be allowed to borrow from the Health Insurance Trust Fund, paying back the loans, at market interest rates, during the 1990s.

2. REALLOCATING SOCIAL SECURITY TAXES -- Under present law, too much of the social security tax rate has been allocated to Disability Insurance and too little to Old Age and Survivors' Insurance. That has contributed to the current financial bind, and an adjustment in the tax rate is long overdue.

3. BORROWING FROM THE TREASURY -- Social Security should be given back-up authority to borrow from the general fund, just as state unemployment insurance programs borrow from the Treasury, and have done so for years. The loans would be repayable at market interest rates. It probably won't ever be necessary to do such borrowing, but knowing that the authority to do so exists would reassure workers and retirees that social security will always meet its obligations.

4. REMOVING SOCIAL SECURITY FROM THE UNIFIED BUDGET -- Prior to Fiscal 1969, the Social Security Trust Funds were completely autonomous. Then they were swept into the unified Federal budget where they have had to compete with other social and defense expenditures. Restoring social security's separate status would insulate the program against the short-term policy swings of elected officials and political appointees, and would safeguard against the misuse of social security for budget purposes. As long as social security remains in the unified budget, there can be no support for a so-called balanced-budget Constitutional Amendment.

5. PROVIDING GENERAL REVENUE FUNDS FOR PART OF MEDICARE -- At present, 75 percent of the cost of insurance coverage for physicians' services is met from Federal general revenue funds. We support the concept of having up to one-half of the cost of hospital insurance coverage under Medicare also paid from this same source.

6. RECREDITING OUTSTANDING CHECKS -- Some social security checks have never been cashed, and over the years the amount has built up to a sizeable sum. The money to cover these checks has been transferred from the Trust Funds and has never been recredited. Under a policy of crediting these checks after a reasonable time, the Trust Funds would recoup $225 million in Fiscal 1982.

7. ANNUAL ROLLOVER OF TRUST FUNDS -- At present, the overall yield on Trust Fund investments is 8.5 percent -- far below the recent yields of well over 14 percent on long-term Federal securities. If the Trust Fund investments carried a one-year maturity, the interest income to the funds would be more closely in line with market yields. In 1981, for example, this would have increased interest income by $1.7 billion. Over the past 21 years, it would have increased interest income by $14.9 billion.

8. SAFEGUARDING HEALTH BENEFITS -- The government must assure continuation of present Medicare and Medicaid benefits without requiring beneficiary payments beyond what the law already requires. We support the Health Security Action Council's cost-containment program designed to control cost increases in the entire health-care system.

9. PROTECTING DISABILITY BENEFITS -- We oppose the Administration's proposals, and the proposals of some in Congress, to cut back disability benefits and to arbitrarily impose across-the-board cutoffs which would terminate benefits for qualified disabled persons and their families.

10. ADD PUBLIC MEMBERS TO THE BOARD OF TRUSTEES -- At present the Trust Funds are administered by the Secretaries of the Treasury, Labor, and Health and Human Services. The voice of the people needs to be heard in the handling of Trust Funds which so directly affect the economic well-being of 36 million beneficiaries and 116 million contributors.

11. A BIPARTISAN BOARD TO RUN SOCIAL SECURITY -- People should feel secure that their rights will be respected. It is not enough to have the system operated as part of a Cabinet Department with a President appointing both the Cabinet Secretary and the Social Security Commissioner. This is a huge pension and group insurance plan, and the policy function should be performed by a bipartisan board of directors. The power to set benefits and finance the program would remain with Congress and the President, but social security is a people's program and they should have a voice in the policy-making decision process.

12. A COST-OF-LIVING STUDY -- Disagreements abound as to whether the Consumer Price Index correctly reflects the impact of inflation on the elderly. Some argue that it overstates the housing component; others argue that it understates the medical, food and energy components. A high-level advisory council could make recommendations to Congress as to the most accurate way to measure cost-of-living increases for social security beneficiaries, and Federal and military retirees.

13. RESTORING THE MINIMUM BENEFIT -- When the Reagan budget was adopted in 1981, it eliminated the $122-a-month minimum. Congress later reversed this action and restored the benefit for those already on the rolls as of Dec. 31, 1981. The minimum should be restored for all future beneficiaries, as well.

14. RESTORING THE STUDENT BENEFIT -- The 1981 Federal budget phased out benefits for young dependents going to college. This cut adversely affects some 700,000 college-bound students right now; it could adversely affect the opportunity for higher education for some 5 million additional youngsters by the end of the century. The student benefit should be restored without qualification.

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Senator ARMSTRONG. Dr. Talbott of Cornell University.

STATEMENT OF JOHN TALBOTT, M.D., PROFESSOR OF PSYCHIATRY, CORNELL UNIVERSITY MEDICAL COLLEGE, NEW YORK, N.Y., REPRESENTING THE AMERICAN PSYCHIATRIC ASSOCIATION, WASHINGTON, D.C.

Dr. TALBOTT. Thank you, Mr. Chairman.

I have an 18-page statement which I would like to have placed in the record of this hearing, and I will merely summarize some of the major points.

Senator ARMSTRONG. We will be very glad to print the statement in full in the record.

Dr. TALBOTT. Thank you, Senator.

My name is John Talbott, and I am a trustee of the American Psychiatric Association, a medical specialty society which represents over 27,000 psychiatrists nationwide. I am also chairman of that association's Committee on the Chronic Mentally Ill, and a professor of psychiatry at Cornell, as you mentioned.

My testimony today, however, will be not only on behalf of the American Psychiatric Association but on behalf of 16 other provider, consumer, and professional organizations in the field of mental health, as well.

Mr. Chairman, we are aware of the urgent need to eliminate fraud and abuse and to insure that SSDI beneficiaries are truly eligible for their benefits because of their inability to work. However, we firmly believe that the administration's current approach is contrary to the letter and spirit of the careful review mandated by law. It works a special hardship on the mentally ill and actually costs the Nation more through these processes than if reviews were conducted properly.

I would like to summarize three points for you that pertain especially to the mentally ill:

First, the consequences of the speeded-up review process;

Second, the SSA's failure to follow Congress mandate; and

Third, the special difficulties encountered by the mentally ill:

First, the speeded-up review process. The speedup has left States with inadequate numbers of both trained claims reviewers and medical personnel trained to evaluate mental illness. As a result, reviews are often perfunctory and lack adequate psychiatric and other medical evaluation.

A very telling point that has been made here before is that the mentally ill who, on paper may look one way, frequently are so obviously disabled that when there is a face-to-face appeal, an initial decision to terminate benefits is often reversed. That is a very important point.

The second point has to do with the failure to follow the legal standards of disability. Frequently, neither the law nor the five-step procedure outlined by SSA is being followed. First, of course, there is the determination of whether the person meets or equals the medical listings; and, if not, then there should be a determination of vocational factors. Now, there are problems with this. Some officials are publicly instructing reviewers to disregard the vocational factors; and second, even if the vocational factors are evaluated, it is frequently a paper evaluation. The person frequently looks good on paper, but we know that many patients can function only in a sheltered vocational workshop but not in the real marketplace: they cannot take buses, they have to have a professional side-by-side with them to operate, and so forth, all things that you are well familiar with.

In addition, a puzzling paradox has arisen that has been pointed out already. Patients are being disqualified now who have shown no medical improvement since they became eligible for SSDI. And, in the field of psychiatry, there have not been major technological gains in the last 10 years; the major medications were introduced in the 1950's, so notwithstanding refinements in drug therapy and improved diagnostic methods, we have not seen technological leaps that have eliminated the medical conditions in many people who are mentally ill.

Third, I would like to talk about some specific problems of the mentally ill. Severe and chronic mental illness interferes with the individual's ability to perform the simple tasks of everyday living that you and I take very much for granted—taking transportation, participating in interviews, receiving work supervision, or thinking clearly. You can understand that depressed people frequently can do hardly anything, even get out of bed. Schizophrenics are unable to think in the same logical, coherent manner we are, or to follow directions. Agoraphobics are afraid, indeed, of going outside and even traveling at all.

The review forms will arrive, and the patient will panic or get depressed and may not fill out the form at all, or does so incompletely, because of the mental illness. The answers also may be inappropriate because of distorted thinking or a patient's perception of what response is expected of him or her. Or a patient may think that unless he or she says that he or she is well, the patient will be rehospitalized.

The consequence is that, if the forms aren't filled out, frequently the benefits may be stopped. And if rehospitalization occurs, you are now dealing with a cost that is 10 times that of the current disability benefit.

Now, consultative examinations ordered by SSA with the mentally ill are also quite difficult. Oftentimes they are located in a central location; they are hard to get to for those people, again, who have difficulty negotiating transportation systems. As has been pointed out earlier, frequently patients with psychiatric conditions have fluctuating mental states and may look quite good, without delusions or hallucinations one minute and have them the next.

The appeals process is something that baffles many of the mentally ill. Many of the mentally ill can't even comprehend an appeals process, and its availability is unknown.

The fact that benefits are not continued until the appeals process finally reaches the administrative law judge review is another problem.

Now, let me just briefly state 10 points that we feel are important in terms of solutions—three short-term solutions and seven longer term issues:

First, short-term solution has to do with requiring SSA to show that medical improvement has occurred. Brought up many times today, we would strongly support that;

Second, slowing down the CDI process—again, brought up today. We would strongly support that; and

Third, continuing benefits until the appeals process has been exhausted.

There are some longer term issues that also need to be considered carefully:

One. To require that SSA procedures be consistent with the statutes;

Two. To review the strictness of the definition of "disability" as it applies to mental illness;

Three. To perform real workshop evaluations in real situations so that we are able to see how and if people are able to work;

Four. To establish stronger guidelines on consultative evaluations;

Five. To require face-to-face contact with the mentally ill at the first level review;

Six. To hire and train enough examiners and medical staff;

Seven. And, finally, to bring the medical listings into conformity with established medical terminology.

Mr. Chairman, I look forward to working with you, Senator Dole, your staff, and SSA, to work out the best solution to this terrible problem which affects thousands of our fellow citizens who were recently working but are now mentally disabled.

Senator **Armstrong**. Thank you very much, Doctor, we appreciate your statement.

[The prepared statement of Dr. John Talbott and answers to question from Senator Armstrong follows:]

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STATEMENT

of

AMERICAN PSYCHIATRIC ASSOCIATION
AMERICAN ACADEMY OF CHILD PSYCHIATRY
AMERICAN MENTAL HEALTH COUNSELORS ASSOCIATION
AMERICAN NURSES' ASSOCIATION
AMERICAN OCCUPATIONAL THERAPY ASSOCIATION
AMERICAN PSYCHOLOGICAL ASSOCIATION
ASSOCIATION FOR THE ADVANCEMENT OF PSYCHOLOGY
ASSOCIATION OF PSYCHIATRIC OUTPATIENT CENTERS OF AMERICA
CHILD WELFARE LEAGUE OF AMERICA
FAMILY SERVICES ASSOCIATION OF AMERICA
MENTAL HEALTH LAW PROJECT
NATIONAL ALLIANCE FOR THE MENTALLY ILL
NATIONAL ASSOCIATION OF PSYCHO-SOCIAL REHABILIATION SERVICES
NATIONAL ASSOCIATION OF SOCIAL WORKERS
NATIONAL ASSOCIATION OF STATE MENTAL HEALTH PROGRAM DIRECTORS
NATIONAL COUNCIL OF COMMUNITY MENTAL HEALTH CENTERS
NATIONAL MENTAL HEALTH ASSOCIATION

on the

SOCIAL SECURITY DISABILITY INSURANCE PROGRAM

PRESENTED BY

JOHN TALBOTT, M.D.
MEMBER, BOARD OF TRUSTEES
AMERICAN PSYCHIATRIC ASSOCIATION

BEFORE THE

SENATE COMMITTEE ON FINANCE

AUGUST 18, 1982

SUMMARY

Overview

The SSA's accelerated Continued Disability Investigation process, is working an undue hardship on mentally ill disability beneficiaries who, by virtue of the illness itself, are particularly vulnerable.

The difficulties are based in:

- (a) The failure to follow the legal standards of judging disability established by Congress;
- (b) a process which, both in regulations and Procedure and Operations Manual is insensitive to the special nature of mental illness:
  - (1) inappropriate self-completion forms;
  - (2) insufficient attention to clinical record;
  - (3) failure to consider vocational factors of critical import for the mentally ill;
  - (4) failure to recognize the fluctuating and intermittent nature of profound mental illness;
- (c) a speed-up begun 9 months before the Congressional mandate which further compounds already cited difficulties due to:
  - (1) inadequate numbers of trained claims examiners;
  - (2) a documented shortage of medical professionals trained in mental illness evaluation on state staff;
  - (3) incomplete, inappropriate or otherwise lacking consultative examinations.

The result has led to a 400% increase in backlogged cases at the State level; a 45% cessation rate with a correlary 67% reversal rate of cessations appealed to an Administrative Law Judge; the apparent wholesale termination of mentally ill from the DI rolls as one of a series of "targeted" populations under heightened, inappropriately tightened SSA sub-regulatory criteria.

Recommendations

Short term, immediate

- -- shift the burden of proof to SSA to prove evidence of medical improvement (or that the original decision granting benefits was clearly erroneous) based on the standards in effect when the beneficiary was placed on the rolls, before SSA may terminate benefits;
- -- slow down the CDI process to assure that the reviews are being accomplished fairly and accurately; and
- -- pay benefits through the Administrative Law Judge appeals level;

Longer term,

- -- require that sub-regulatory procedures are consistent with statute;
- -- review stringency of definition of disability as it applies to mental illness;
- -- clarify requirements in current law regarding vocational factors as they apply to mental illness including the use of valuable workshop evaluations;
- -- establish stronger guidelines on nature of consultative examinations
- -- face-to-face interviews with mentally ill at first level review for both new and continuing SSDI recipients
- -- assure sufficient numbers and adequate training of claims examiners and professional medical staff to review cases of mentally ill;
- -- assure consistency of nomenclature between medical professionals and SSA manuals.

Mr. Chairman, Members of the Committee, my name is John Talbott, M.D. I am a Trustee of the American Psychiatric Association, a medical specialty society representing over 27,000 psychiatrists nationwide, Chair of the APA's Committee on the Chronically Mentally Ill, and I am also Professor of Psychiatry at the Cornell University Medical College, in New York City.

My testimony before the Committee today is on behalf of the APA and American Academy of Child Psychiatry, American Mental Health Counselors Association, American Nurses' Association, American Occupational Therapy Association, American Psychological Association, Association for the Advancement of Psychology, Association of Psychiatric Outpatient Centers of America, Child Welfare League of America, Family Services Association of America, Mental Health Law Project, National Alliance for the Mentally Ill, National Association of Psycho-Social Rehabilitation Services, National Association of Social Workers, National Association of State Mental Health Program Directors, National Council of Community Mental Health Centers, National Mental Health Association and all mental health provider and citizens organizations.

I am pleased to present our views and concerns regarding the Administration's ongoing efforts to review the current Social Security Disability Insurance (SSDI) rolls. We are very much aware that periodic review of disability cases is necessary not only to reduce fraud and abuse, but also to confirm that SSDI recipients continue to meet eligibility requirements and remain unable to work. However, the Administration's current approach, in an apparent excess of zeal to reduce Federal expenditures, we believe, is contrary to both the letter and the spirit of the careful review that was mandated by Congress in the Social Security Disability Amendments of 1980. Moreover, SSA's reviews are being conducted in a manner contrary to sound medical practice, and sound professional clinical practice. Not only is the program administratively confusing and awkward for the recipients, physicians, health and mental health professionals, state officials and judges involved in it, but it works a special hardship upon the mentally ill SSDI recipients who, by virtue of their illness itself, are particularly vulnerable.

Not only are the mentally ill themselves hurt, but SSDI terminations are affecting spouses and children -- entire families. The ripple effect of SSDI termination is tremendous, taking a toll on health coverage, other means of support provided at either the Federal or state level including SSI and State welfare. For the spouse or parent of a chronically mentally ill individual, the burden of care alone is substantial. Often times, employment is difficult under the best of circumstances, but in this economy, the ability of a family member to seek and retain employment to replace SSDI payments is severely hampered. SSDI is and must remain part of the so-called social safety net for the nation's least able to help themselves. It is important to remember that the disability program is like workers' compensation, as contrasted to welfare. Disability insurance is earned. It is not a hand-out. To terminate these benefits to which a worker is entitled by virtue of his or her illness, is wholly inappropriate, wholly misguided.

The Situation

In March, 1981, the Social Security Administration began an accelerated review of the claims of people receiving SSDI benefits, a review which

Congress mandated be conducted beginning January, 1982. The delay Congress, indeed this Committee, established was intended to permit the states the opportunity to bring added personnel on board to handle the substantially greater workload engendered by the adoption of the Act in 1980.

Nonetheless, SSA began these reviews nine months prior to the Congressionally mandated date. In FY 1982, the Administration hopes to complete 520,000 such reviews, as contrasted to 200,000 conducted in FY 1980. According to a Social Security Administration document of March 11, 1981 (copy attached), OMB "proposed through improved and tightened management of the continuing disability process, that SSA find a way to save the trust funds an additional $200 million in savings in 1982" (emphasis supplied). These continuing disability investigations (CDIs) undertaken since that time, constitute the SSA response to the OMB directive. Among the means of acheiving the OMB-mandated savings, again according to the SSA document, were to: increase the required number of cases states must review each month (adding 20,000 further cases monthly beginning May 1981, and upping that number of 31,000 further cases monthly in FY 1982); targeting the non-permanently disabled SSDI recipients over review of disabled SSI recipients since the potential savings from the SSDI cases would be greater; and defer the requirement of personalized denial notices (mandated by law) to "free personnel to concentrate on reviewing disability claims."

What these recommendations have led to has been a nightmare for the state-level review agencies. Those agencies, charged with the initial review (as well as with the first level reconsideration of disputed denials and terminations) are under tremendous pressure, without adequate time to "gear up" and without adequate staff to handle the increased review load. As a result, reviews are often perfunctory, without adequate medical evidence, and with insufficient attention to individual problems. Indeed, the SSA directive regarding the relocation of individuals from producing personalized denial notices into handling the review process, highlights a deeply disturbing component of the problem: staff who are inadequately trained to read and evaluate appropriately medical or psychological records submitted (when time permits) by attending physicians or other treating professionals. Further, the SSA has argued that by beginning its review process nine months earlier, it has actually spread the new workload imposed on the state agencies out over a greater time frame, thereby easing their burden. However, the evidence is to the contrary. The impact of initiation of the reviews in FY 1981, rather than midway through FY 1982, has merely added a full year's worth of additional reviews to the state agencies' already overburdened workload. It is hard to believe that, with this increased volume, any examiner, even one who is well trained, could give appropriate time and attention to the medical and other documents comprising an SSDI recipient's claims record. Further, the increased workload of those physicians and other health professionals working in the state agencies assures that insufficient time can be given to permit a thorough physical and mental evaluation of the recipients undergoing the CDI review. Moreover, consultative examinations often purchased on a bulk basis, whether from physicians or other health care providers, simply cannot be accomplished accurately and adequately, particularly for the mentally ill DI recipient, under the current speed up.

Mr. Chairman, the data from SSA itself are clear on their face. In March, 1981, when the SSA began its accelerated review, there was a backlog of just 40,000 cases (breaking down approximately 80 percent SSDI; 20 percent SSI). As of April 30, 1982, one year and one month after the accelerated review began, that backlog had increased by 400 percent, up to 202,987 cases outstanding nationally. (These include approximately 50,000 diaried cases; the balance is attributable to the accelerated CDI. Again the split is approximately 80 percent SSDI and 20 percent SSI.) The average national backlog of cases is estimated to be of 4.9 months duration. That is, if all new reviews were held by SSA, it would take, on an average, 4.9 months for all states to clear their backlog. In New Jersey, the backlog is 9.98 months; New York, 8 months; Pennsylvania, 6 months; Delaware, 14.3 months; Texas 6.8 months.

We understand that the backlog can only worsen. It is estimated that in FY 1983, over 700,000 cases will be subject to review, up 40% over the approximately 500,000 cases under review this year. At the same time, SSA state agency staff has increased by only 27% nationally since passage of the 1980 amendments. The backlog is increasing at a rate of over 12 times the rate that "additional resources" at the state level are being added. The personnel simply are not there. The sheer volume of cases and the serious understaffing at the state agency level has led to a monstrous error rate. Of the 174,000 persons whose benefits have ceased in the last 15 months (45% of all reviews) and who have sought adjudication before an Administrative Law Judge, fully 67 percent of the terminations are reversed. This is far more than any acceptable margin of error and 20 percent above the rate predicted by SSA itself. Thus the accelerated CDI review is forcing cases to be handled inadequately at the initial review level, to be "rubber stamped" at the reconsideration level, and to be reviewed and often overturned at the Administrative Law Judge level. I will speak more about the problems in the process per se hereafter.

The Mentally Ill

The nightmare is even greater for the SSDI recipient, and specifically the mentally ill SSDI recipient. The review procedures are not designed to recognize the very special limitations of these SSDI recipients. When a case is pulled for CDI review, the state agency mails the disability recipient a three-page form seeking detailed information about his or her medical condition and employability. A copy of that form is appended to my testimony. If this form is not completed and returned within 35 days of mailing, we understand benefits are often terminated, notwithstanding SSA directives to "go the extra mile" for the mentally ill.

Many of the severely mentally ill, the disabled, capable of living in community-based settings as long as they receive proper therapeutic services, medication (if necessary) and social services to control their symptomology, are unable to understand that their only source of income is being threatened, that their Medicare benefits (or Medicaid in the case of SSDI beneficiaries receiving SSI supplementation and therefore Medicaid benefits) -- the source of payment for their continued treatment -- are being threatened. They often do not understand the complexity of the forms, or the necessity of such forms being completed. They either neglect to return the forms, or to complete them adequately and, as a direct result of their disabilities, lose their monthly support (a sum far lower than that associated with hospitalization, often the only recourse when SSDI benefits are terminated). The problem is compounded by the failure to provide the appropriate follow-up in cases in which forms are not completed, to attempt to ascertain why such form was not returned, to seek the advise and counsel of an attending physician who has previously attested to the continuing disability of such person.

Moreover, given the nature of mental illness itself, it is often inappropriate if not impossible to receive an accurate self-evaluation from a mentally ill SSDI recipient using such forms. It is the very nature of the illness which causes a patient to deny or distort the medical significance of such illness. In a sense, the completion of the CDI form requires a person to make statements about him or herself which, based upon the serious mental, as opposed to physical, nature of the illness, are almost by definition going to be inaccurate.

A hypothetical example of a mentally ill disability recipient's reaction to the receipt of a notice of proposed termination may be instructive in light of the foregoing:

Mrs. X., age 47, is a chronic schizophrenic. She has spent the majority of her life in state institutions, but was deinstitutionalized 5 years ago to a halfway house. She has been maintained on psychotropic medication, which has assured that her symptoms are not obviously disruptive to those around her, but has not "cured" the illness. She has been determined to be medically disabled and not capable of substantial gainful activity. She, thus, has been eligible for and has received both SSDI and Medicare benefits (the latter after two years on the SSDI rolls). She has sought employment, but has been unable to find such employment, and remains delusional, though not overtly evidencing her symptoms in her outward demeanor. She continues to hear voices, and is unable to devote any concentration to any job. Each time she is placed in a work-like environment by the halfway house mental health personnel, she decompensates, falls apart, and is unable to manage herself. She receives a notice that a CDI is to be conducted and is instructed to complete the three-page form. As is the case with many of the deinstitutionalized chronically mentally ill, she does not wish to be rehospitalized. She fears that unless she proves that she is "well" and "employable" or "employed" on the form, that she will be recommitted to a state institution. Thus, she completes the form inappropriately, indicating that she has no physical or mental impairment, and that she has sought employment. (Indeed, given the nature of the illness, she may actually believe this to be true). She may even "create" a work history. Her disability benefits are then terminated, based upon her report of wellness. She is reinstitutionalized.

What we find disturbing about the CDI process is not only the apparent disregard for the complex and special nature of mental illness in this initial data-gathering, but also that the case record of a current SSDI recipient is not appropriately and accurately reviewed by state agency medical staff sufficiently qualified to make an appropriate (if necessarily different from the claims examiner) judgement about a mentally ill patient. We know, for example, from a recent letter from Secretary Schweiker, following a meeting by the Medical Director of the American Psychiatric Association with the Secretary on the SSDI issue, that fully 27 states do not have sufficient numbers of psychiatrists on their medical staffs to perform appropriate reviews of mentally ill SSDI recipients' records. While the APA is working with the Secretary to seek means of relieving this tremendous short-fall of personnel, we find the current practice which essentially disregards an existing clinical history to stand in clear opposition to procedures assuring a full and sound professional evaluation. The requirement that a medical record be wholly redeveloped, upon notice of a CDI, further places an undue hardship upon the patient and his or her treating professional, if one exists.

In a May, 1982, statement, reporting on their review of SSA's continuing disabilty investigations, GAO expressed a shared concern in this regard. They noted:

> "One aspect of State agency medical development that we feel needs to be changed is the practice of developing the ACDI/Periodic Review cases as if they were new claims. SSA has issued no specific development guidance for these cases, but rather has instructed the State as initial claims. As a result, State agencies are gathering only current evidence -- generally no more than 2 or 3 months old -- and using this evidence to determine if the beneficiary currently meets SSA's criteria for disability. This practice can result in incomplete information and is one of the major reasons treating sources are not contacted or their information is not considered in the decision. It also helps explain the high consultative examination purchase rate. While the need for current evidence is obvious, we also believe there is a need for a historical perspective in these ACDI cases. Many of these individuals coming under review have been receiving benefits for several years. To base a decision only on the recent examination -- often a purchased consultative examination -- could give a false reading of that person's condition.

This is especially true for those impairments subject to fluctuation or periodic remission, such as mental impairments." (emphasis supplied)

We have received reports from members of the American Psychiatric Association, Mental Health Association, American Psychological Association and many other organizations which I am pleased to represent today, that their severely ill patients, or family members or friends now receiving SSDI benefits are being closely scrutinized by the state agencies responsible for SSDI review and, in many cases, benefits have been terminated, contrary to the medical opinion of the consulting physician and that of psychologists or social workers performing other evaluations of the patient. It is unclear whether consultative evaluations were conducted in many cases. However, were such evaluations conducted, the evidence presented by the consultative physician was probably in conflict with that of the attending physician, and the patient was terminated from the rolls without regard to the report of the treating physician (notwithstanding an appeals court ruling that special consideration be given to the reports from such treating physicians and other professionals - Dav V. Weinberger, 522 F. 2d 1155 (9th Cir. 1975).) It is also entirely possible that the recipient did not appear for such consultative evaluation, often held in a single centrally-located place in the state. This would not be particularly unusual for a mentally ill SSDI recipient particularly since he or she may well continue to deny his or her illness.

A series of cases, from a single day-treatment program in New York are illustrative of the problem. Of 10 individuals subjected to CDIs, all 10 were terminated, notwithstanding clear and carefully developed medical histories and psychological evaluations. One case, of a floridly delusional psychotic barely able to be maintained in an environment outside the hospital, which APA Medical Director shared with Secretary Schweiker, was found by the Secretary himself to be an inappropriate termination. We can accept some error tolerance, but 10 of 10 seems highly suspect. We further suspect that were it not for an involved and concerned staff at that facility, who helped these individuals appeal their termination notices, many would not today have been restored to their place on the SSDI rolls.

It is fair to ask how such inappropriate terminations occur. Perhaps it is the combination of the above-cited factors, coupled with problems engendered in the law, the operating procedures under which claims are reviewed, and the regulations and sub-regulatory interpretive material such as the POMs which have led to the termination of the mentally ill from the SSDI rolls at a rate of 30 percent although they represent only 11 percent of recipients.

For example, the statutory requirement that a person be deemed ineligible for SSDI if he or she has the residual functional capacity to perform any work available in the national economy has certain unique perverse repercussions for the mentally ill. The availability of employment which, it would appear a mentally ill person may be able to perform, does not mean, for such individuals, that such employment is possible. I am sure you understand, for example, that it is often impossible for a mentally ill person to negotiate a ten-block bus ride to a place of employment by virtue of the illness itself. We recognize the generic value of a strict definition, but note that for the mentally ill, it is a seriously flawed definition.

As noted, other difficulties are based in practice -- operating procedures which, due to the tremendous volume of casework now thrust upon the separate state claims examiners may not be consistent with SSA regulation. The requisite that extra caution be paid to the mentally ill case under review by the claims examiner, as cited earlier, is such an example, as are inadequate numbers of both staff psychiatrists and psychologists.

Yet other problems, particularly for the mentally ill, are based on regulation -- the so-called "Medical Listings" -- and on SSA's interpretive documents, the Program Operation Manual System (POMs). Members of the American Psychiatric Association's Committee on Rehabilitation recently completed a chapter -- "Mental and Behavioral Disorders" -- which will appear in the new AMA publication, Guides to the Evaluation of Permanent Impairment, and which provides invaluable advice and sets forth principles which may well be more appropriate guides upon which claims examiner should rely when interpreting the "Medical Listings." Indeed, the Listings bear little relationship to our chapter, and the POMs even less.

As you are probably aware, the SSA recently republished the Listings in draft form for public comment. Regrettably, no substantive changes were made in the mental impairment section, notwithstanding the publication over a year ago of a new Diagnostic and Statistical Manual of Mental Disorders (DSM-III) which sets forth current psychiatric nomenclature. Thus, the terminology utilized in the Listings bears little resemblance to the nomenclature utilized in medical and psychological case histories of mentally ill SSDI recipients. SSA state claims examiners, in effect, are forced to "translate" case record statements to language contained in the regulations and POMs before they can begin the evaluation process. Since they are not trained in the psychiatric or psychological nomenclature, such translation is difficult if not impossible. Thus, case histories which are wholly complete, may be found to be insufficient based on the discrepancies in terminology utilized. The only safeguard could be the professional medical staff in the state agency, but as mentioned earlier, many are not trained psychiatrists or psychologists and are also therefore not current on DSM-III nomenclature.

The regulations pose yet other problems in their construction. We have commented, both on behalf of the membership of the Liaison Group for Mental Health as well as in our individual organizational capacities, to SSA, on the precise changes we recommend in the Medical Listings per se. These included: changes in the requirement that certain signs and symptoms be manifest at the time of the evaluation -- not necessarily the case in most forms of mental illness which is characterized by intermittent persistence --; and a modification in the impairments which, in combination with the signs and symptoms, form the basis for a determination of disability.

As important as the regulations, however, in the evaluation of disability conducted by state claims examiners are the POMs. These sub-regulatory documents (constituting some 13 volumes of material and constantly changing) are the operating guidelines for claims examiners. We have discovered some serious difficulties with these documents as well as with other sub-regulatory interpretive material. They are leading to the flagrant disregard of the SSA's own five-step procedure for the determination of disability. Portions of the interpretive material may indeed be in violation of the law.

The law states that both medical and vocational factors must be considered in the determination of disability. The regulatory interpretation of the law has been to establish a five-step process to make such determination. As noted above, "meeting" or "equaling" the Medical Listings establishes per se disability. If someone does not meet or equal the Listings, however, regulations instruct claims examiners to take the next step, that is to look toward vocational factors -- establishing what residual functional capacity an individual may have which would enable him or her to work. However, in the case of the mentally ill this often cannot be ascertained in the usual procedure (i.e., based on the clinical record) because non-clinical, judgmental information, such as a statement that a patient is not able to work is disregarded by claims examiners. Rather, the claims examiner is expected to discern such information on his or her own. Thus, while a mentally ill individual may appear to function in a "work environment" such as a sheltered workshop or day-treatment program, the claims examiner neglects or fails to understand the critical and atypical nature of that setting -- close, clinical supervision in the work setting -- which alone enables the individual to work. When such supervision is withdrawn, the patient rapidly decompensates, regresses, and is incapable of employment of even the most unskilled sort. Hence it is often the case that a mentally ill person may not meet or equal the Listings, but may be wholly unable to work due to the pressure of the employment situation itself. Such finding could only be ascertained by a work evaluation, which is not conducted on a routine basis, if at all, by state claims examiners.

The situation has been further compounded by a draft POMs directive which urges state claims examiners to rely on the psychiatric review form alone for a determination of residual functional capacity, specifically recommending against the usefulness of workshop evaluations.

Yet another aspect of the same problem, where SSA interpretation wholly contradicts the law and regulations to the detriment of the mentally ill can be found in the text of a state claims examiner training conference. In an addendum by Dr. Blumenfeld (Medical Chief for the Disability Office in Baltimore), it was noted that when "the overall psychiatric rating (is) less than meets or equals (the Medical Listings), the individual retains a mental RFC (residual functional capacity) for at least some type of unskilled work activity." (parenthetical clarification added). Dr. Blumenfeld, in direct violation of the five-step SSA regulations and the law itself, has recommended that vocational factors be ignored for the purpose of establishing disability in the mentally ill.

In response, the Michigan Department of Education, which houses the state disability review office, stated that "It is recognized that this is a significant change from the way we have been evaluating and adjudicating those cases. While we have submitted a policy question to the Regional Office on this issue, it is not anticipated that the policy will be altered." In its policy question to SSA, the State official noted "we would not agree with the statement the '...when a mental impairment does not meet or equal the listing it will generally follow that the individual has the capacity for at least unskilled work.' We feel this position is logically inconsistent with current manual guidelines." The policy has not been altered to date, to our knowledge.

The impact of Dr. Blumenfeld's determination will be simply to work yet another hardship upon the mentally ill disability recipient, setting him (or her) apart from other disability beneficiaries, subject to different criteria, based solely on the nature of the illness. If the stigma of mental illness is still with us, it is only heightened by such pronouncements from Federal agencies. Worse, it is in violation of the law.

These are just two examples of what we expect are many inconsistencies between SSA policy and law.

In a recent investigation, GAO found that the key problem in determining continued eligibility of the mentally ill and other SSDI recipients is that different and more stringent evaluation guidelines are in effect today than at the time benefits were initially granted. The above cited examples clearly demonstrate such changes in the standard, and their inappropriateness. GAO found that "Many of those losing their disability benefits have been on the SSA roll several years, still have what we would consider to be severe impairments, and have experienced little or no improvement." GAO noted that SSA's own study found that "in 35 percent of the cases, benefits were ceased even though the severity of impairments was judged to be the same or worse than when benefits were initially awarded." GAO's recommendation was the "Congress should state whether cessations are appropriate for those already on the disability rolls who have not medically improved."

We concur with GAO's assessment, and believe that in the case of cessations, the intended result of the CDI process, the burden of proof should be upon SSA to demonstrate medical improvement based upon the standards in effect when the individuals were first brought on the rolls. To do otherwise is a gross injustice.

The Process

Although denial or cessation of disability benefits can be appealed, the process does not seek to maintain the SSDI recipient in the community during that period. SSDI recipients lose all benefits shortly after receiving a termination notice -- including Medicare benefits and Medicaid if the DI beneficiary is receiving SSDI supplementation. During the time their appeal is pending, which -- notwithstanding a court-ordered 165 day time limit between termination and appeal -- can often be over a year, the former recipient receives no benefits. Even if benefits are then reinstated, many severely disabled individuals will have already lost their homes or will have been forced to discontinue residential or treatment programs.

Many terminated recipients do not know their right to appeal to an Administrative Law Judge (ALJ) if their first level of appeal ("reconsideration") fails; many do not have the capacity to do so; and many have already been reinstitutionalized and cannot do so. We do know, however, that many of those individuals seeking redress at the ALJ level -- over 65 percent of them -- have their benefits restored. We have wondered about the difference between the initial process (including reconsideration) and the ALJ appeal. The answer appears to be several:

-- the ALJ has a face-to face meeting with the recipient, and is thereby better able to review aspects of demeanor, affect, functional ability that are easily visible to the eye;

- -- the patient may well have deteriorated in the period intervening between reconsideration and the ALJ hearing;
- -- and most important, the ALJ is bound by the statute and regulations, whereas the state level officials rely upon the POMs and other SSA directives which are not necessarily consistent with either the law or regulations, as noted above.

What has resulted has been a tragedy. Between cessation notice and ultimate restoration of benefits, the disabled individual is cut off the SSDI rolls in what amounts to a false economy in both human as well as monetary terms. The average amount of time between a denial at reconsideration and the Administrative Law Judge hearing, on a national basis, is 173 days (ranging from a high in Federal Region V of 221 days to a low of 142 days in Region IV). Further, as many as 100 days can lapse between the first notice of termination and the reconsideration hearing; and another 45 days of processing time to restore the beneficiary to the rolls are necessary if an ALJ hearing overturns the cessation. Thus, on the average, a legitimately enrolled SSDI recipient may be inappropriately cut off the DI and Medicare rolls for as long as 10 months to a year. In some states, that number may run as high as 18 months.

The Response

We know that House legislation, H.R. 6181, seeks to resolve several of these complex and misguided results of the 1980 Disability Amendments. However, we believe that the legislation fails in several critical respects, and each organization has opposed the legislation in current form.

We are also aware that SSA has indicated that it is seeking to resolve the problem, but is faced with financial constraints from OMB.

We believe that the bills which have been introduced in the Senate by Senators Cohen, Heinz, Levin, Metzenbaum, Riegle and Sasser pose reasoned solutions to not only the longer term problems of the SSDI program itself, but appropriate short-term solutions to the urgent problem now by the accelerated

CDI review process.

The APA and its colleague organizations joining in this testimony believe that three actions are urgently needed, as soon as the House and Senate can act, to end the carnage to which the disabled are being laid waste. They include:

-- shifting the burden of proof to SSA to prove evidence of medical improvement (or that the original decision granting benefits was clearly erroneous) based on the standards in effect when the beneficiary was placed on the rolls, before SSA may terminate benefits;

-- slowing down the CDI process to assure that the reviews are being accomplished fairly and accurately; and

-- paying benefits through the Administrative Law Judge appeals level.

Each of these recommendations is based in my prior testimony, and the rationale for each has been explained in my earlier text.

There are other longer-term recommendations which we believe the Committee should consider as well, each of which has also been raised in our testimony.

(1) Is the definition of disability in use today too stringent as it is applied to the mentally ill disabled? We believe it is.

(2) Should Congress mandate more clearly what is meant by vocational factors to avoid the current failures of the SSA to appropriately assess residual functional capacity in the mentally ill? We believe it should.

(3) Should Congress mandate workshop evaluations as a means of assessing residual functional capacity in cases in which someone does not "meet" or "equal" the medical criteria for establishing per se disability? We believe it should.

(4) How can consultative examinations be conducted so as to assure that adequate time is devoted to case development and a clear assessment of the patient's status, particularly in view of the use of bulk providers?

(5) Should there be special requirements for a first level reviewer (claims examiner) to conduct face-to-face interviews with the mentally ill, either applying for SSDI or undergoing a CDI or both? We believe both should exist.

(6) How can Congress help assure adequately trained personnel at the state level -- both claims examiners, and professional medical staff

specialists to handle the review of the cases of mentally ill SSDI recipients?

(7) Should Congress mandate that SSA maintain nomenclature consistent with current medical and other professional nomenclature? We believe it should.

Mr. Chairman, we have presented what we perceive to be the key problems to be in the current practice of the SSDI program's CDI review process as it is affecting the mentally ill disability recipient. We have posed several important short-term and several longer-term solutions. I hope the Committee will act promptly in both cases, and act to the detrement of no one rightfully on the SSDI rolls or in need of SSDI in the future.

I am grateful for the opportunity to have appeared before the Committee, ans would be pleased to respond to any questions you may have at this time.

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September 13, 1982

The Honorable William Armstrong
Chairman
Subcommittee on Social Security
& Income Maintenance Programs
Senate Committee on Finance
2227 Dirksen Senate Office Building
Washington, D.C. 20510

Dear Mr. Chairman:

With respect to the questions you enclosed with your letter of August 20, 1982 for the hearing record in regard to my August 18, 1982 testimony, my responses are as follows.

I understand your first question to be "Is it possible the high rate of reversals at the ALJ level is a direct result of the backlogged cases at that level?" As noted in my written testimony, we suspect that such backlog is not the basic cause for the reversals. Rather, I suggest the reasons for the high reversal rate, borne out both by GAO's May report and that of the House Select Committee on Aging, include:

(1) the face-to-face meeting between an ALJ and SSDI recipient;

(2) the likelihood that the patient may have deteriorated in the period intervening between reconsideration and the ALJ hearing; and

(3) most important, the fact that the ALJ is bound by the statute regulations and DHHS Secretarial rulings whereas the state level officials rely upon the POMs and other SSA directives which are not necessarily consistent with either the law or regulations. (It is for this reason that we are concerned, for example, about the SSA's current efforts to upgrade portions of the POMs to the level of DHHS rulings.)

Your second paragraph question states: "Why is it important or equitable to demonstrate medical improvement based on the standards in effect when the individual was first brought on the rolls? What is wrong with using current standards which, as you assert, should reflect current medical technology and terminology?"

I believe it is important first to distinguish what is meant by the term "standards." A clear distinction should be made among medical standards, standards as embodied in regulation, and standards which are established pursuant to the POMs or other sub-regulatory documents. We believe that the latter two standards should reflect the state of the medical art.

As I mentioned in my oral testimony, the nomenclature in the regulations is badly outdated and may create difficulty for claims examiners in ascertaining whether the "Medical Listings" are met or not based upon a medical report written in current nomenclature by an attending physician. At the same time, I noted that technology, as contrasted to terminology, has not advanced in the area of treatment of psychiatric disorders as rapidly as we might like. The major psychotropic medications, used to stablize or improve a patient, have been refined over the past twenty years, since they were developed. However, new "breakthrough" drugs or treatments have not been introduced recently. (In contrast, it is important to note that advances have been made in diagnostic technology -- such as the development of the PET scan -- which aid in the initial medical diagnosis of mental illness.)

Unfortunately, "standards" as embodied in the POMs and regulations do not today reflect the medical state-of-the-art. Indeed, at least one new item in the POMs relating directly to the mentally ill, does not even reflect statute. Neither physicians nor the law recommend the disregard of vocational factors in assessing disability of a mentally ill patient. However, the "standard" developed by SSA suggests that those mentally ill individuals who are not able to "meet" the Medical Listings, shall be "deemed" capable of performing some unskilled labor, absent a review of vocational factors altogether. To judge the mentally ill against such a standard, particularly when medical improvement need not be demonstrated, is not, in my opinion in line with sound medical practice or opinion.

In regard to your question "Based on your knowledge of the program, do you believe it is advisable to hold individuals to a standard which is medically outdated?", my response is: clearly not. We would not disagree with those provisions of the law relating to individuals who fail to follow prescribed medical treatment. We remain concerned, however, that both the standards now embodied in regulations and certainly in the POMs do not reflect current medical practice and policy. The reason we support the demonstration of medical improvement based upon the standards (read: regulations, rulings and POMs) in effect when the individual was brought on the rolls is based upon the recent trend to "tighten" the sub-regulatory standards unduly. Moreover, an SSDI beneficiary, placed on the rolls some time ago, and still under physician care for his or her medical impairment or impairments upon which the determination of disability was based, would be receiving state-of-the-art care. If a major breakthrough in treatment were developed for just that impairment or impairments, and it were recommended and prescribed by a physician, the statutory provision regarding failure to follow prescribed medical treatment would prevail.

You asked: "If there are so many problems in obtaining reliable information from the mentally ill, do you believe that state agencies should deal with someone other than the beneficiary, perhaps a guardian?"

We believe that appropriate joint notice to both a beneficiary as well as a legal guardian (if such exists), family, or physician, may be appropriate. We have, for example, suggested the value of a face-to-face meeting at the initial CDI review level for the mentally ill; suggested that outreach on the part of the state agency may be necessary in the case of these individuals. As I mentioned in my testimony, the very nature of mental illness itself, often impedes not only responding appropriately to questions, whether in writing or in person, but comprehension of the magnitude and purpose of the review, the decision-making process and the potential repercussions themselves.

I trust these responses are of further benefit in your deliberations on this most critical issue.

Respectfully,

John Talbott MD

John A. Talbott, M.D.
American Psychiatric Association

JAT/TF:aw

Senator ARMSTRONG. Mr. Stern, secretary of the department of labor and industry in Pennsylvania.

STATEMENT OF MR. BARRY H. STERN, PENNSYLVANIA SECRETARY OF LABOR AND INDUSTRY

Mr. STERN. Thank you, Mr. Chairman.

I have also submitted a lengthy statement, and in the concern of time I would like to summarize my summary, if I may.

Senator ARMSTRONG. That would be very helpful. We of course would be very happy to have your statement in full, and we will make it a part of the record of this proceeding.

Mr. STERN. Thank you.

I am Barry Stern, secretary of the Pennsylvania Department of Labor and Industry, which is the agency responsible for determining eligibility for disability benefits under the Social Security Act.

Like many other States, Pennsylvania has come under intense public scrutiny from claimants, advocates, and the news media with regard to the sharp increase in termination of benefits which has resulted from the application of more stringent Federal eligibility regulations.

Pennsylvania responded early to these problems. Governor Thornburgh directed me to establish a task force to identify the source of these problems that were resulting in complaints from angry and confused beneficiaries. We are happy to see that both SSA and Congress are reevaluating the procedures in ways which parallel some of our task force recommendations. We also note with satisfaction other positive corrective steps that are contained in legislation sponsored by our senior Senator, a member of this committee, Senator Heinz.

It is our position that the adjudication system must be made more humane, sensitive, and responsive to claimants. We believe it is possible, with some modifications, to structure a system which gives each claimant a fair, comprehensive, and personal assessment of his or her disability while meeting reasonable goals of the 1980 amendments.

The basic goal of accelerated review is sound: to remove from the disability rolls those who for years were undeserving recipients of benefits. However, our experience in Pennsylvania has been that in the process of cleansing these rolls some people are losing benefits whose disabilities offer no real prospect of improvement and who have become dependent and conditioned to the prospect of receiving benefits for the rest of their lives.

In support of the Social Security Administration, it appears that some of these problems are being recognized and corrective measures are being taken, about which we have heard earlier today.

Unfortunately, many problems still remain. Adjudicators in Pennsylvania are now required by the SSA guidelines to make their determinations almost exclusively on the current State of the claimant's condition within the past 12 months, with little regard of past medical history.

For example, a 50-year-old widow with a 30-year history of psychiatric disability and with other lesser physical ailments such as arthritis and diabetes was terminated from our rolls. We believe that some deserving recipients are being wrongfully denied through the use of these strict criteria, and that by primarily considering current medical evidence it has a disproportionate impact on the mentally impaired.

Adding to the public anger and confusion is the very high rate of reversals by ALJ's of our adjudicators' decisions. This situation has had the effect of callously pushing already distraught people back and forth, in and out of eligibility.

At least a semblance of uniformity in the process could spare these people considerable anguish.

In addition, the increased workload imposed upon Pennsylvania by the acceleration of these periodic reviews has made it impossible to keep up with the Social Security Administration's processing time requirements.

In the 2 years prior to implementation of the 1980 amendments our average caseload per adjudicator was 88. Subsequent to this implementation in this past June it rose to 125 per adjudicator.

The result has been that it is taking us an average of 210 days to process a periodic review. SSA's target for all reviews, as you are aware, is 70 days, and we would recommend 120 days given adequate staff to more positively and humanely handle the situation.

But even if these problems can be solved, there is a more important one which should be addressed if the purging of social security disability rolls is to be carried out fairly, equitably, and with sensitivity to human needs. There is a crying need for some kind of transitional step for those whose benefits will be terminated. These people need to be gradually eased from their total dependence on social security benefits to a new and altered life situation, that of competitive employment.

As an outgrowth of our task force report, we are putting together the finishing touches on a comprehensive medical/vocational evaluation model for use during the periodic review process—the time after the initial notice of termination, and during the reconsideration of that decision. We plan to submit this to SSA shortly for their consideration.

If I may, I would like to go over the major elements of that model:

First, a detailed interview to obtain work, education, and social history of that person.

Second, a comprehensive medical evaluation by a certified internist.

Third, an evaluation of physical capacity done by a licensed occupational therapist under the direction of a physiatrist.

Fourth, and vocational and work-sample testing to determine how the individual actually performs in a simulated work setting, and if he has skills which could be used in alternative employment.

We estimate that this evaluation model would take an individual somewhere between 12 to 15 days to complete. With changes such as I have described, Mr. Chairman, I believe that we will make significant strides toward achieving the goal I am certain we all share: To insure that the social security's rolls are free from undeserving beneficiaries, to provide a transition between dependence on the system and the task of finding employment, and to guarantee that those with genuinely serious or long-term disabilities continue to receive the help that they so badly need.

Thank you for this opportunity to present the situation in Pennsylvania as I see it, and I will be glad to answer any questions.

Senator ARMSTRONG. Thank you very much for your report, especially for the upbeat, optimistic tone of it for which we are grateful.

[The prepared statement of Barry H. Stern and answers to questions from Senators Heinz and Armstrong follow:]

Statement of
BARRY H. STERN
Pennsylvania Secretary of Labor and Industry
Before the
U. S. Senate Finance Committee
August 18, 1982

Mr. Chairman and Members of the Senate Finance Committee, I am Barry H. Stern, Secretary of the Pennsylvania Department of Labor and Industry, the agency in Pennsylvania which has responsibility for determining eligibility benefits under the Social Security Act. I appreciate the opportunity to appear before you today to present these comments.

INTRODUCTION

There has already been much discussion about the impact of the Social Security Amendments of 1980 and, in particular, the accelerated continuing disability investigations now known as the periodic review.

Rather than amplify on these, my purpose in being here today is to discuss the impact of these amendments on Pennsylvania's program, the problems we face, the initiatives we've taken, and recommendations to address these issues.

From March 1, 1981, through May 28, 1982, the Pennsylvania Bureau of Disability Determination (BDD) received 23,000 periodic review cases, made decisions on 11,000 of these cases, with a termination rate of 35 percent or about 4,000 removed from the SSA beneficiary roles.

PROBLEMS

Like other states, we found ourselves under intense public scrutiny, particularly from the claimants, advocates, and news media, with regard to the sharp increase in termination of benefits which has resulted from application of more stringent federal eligibility regulations.

Beginning in the summer of 1981, the Office of Vocational Rehabilitation (OVR) received many complaint letters and phone calls from disabled Pennsylvanians objecting to the abrupt termination of their disability benefits.

It was not long after, Mr. Chairman, that we in Pennsylvania identified problems with the system, problems relating to sensitivity, to an increased workload for our adjudicators and to wide disparities between the decisions made by adjudicators and those made by Administrative Law Judges (ALJ's).

We are proud to say that Pennsylvania made an early response. When these problems came to the attention of Governor Thornburgh, a Task Force was commissioned to identify the source of the problems which were coming in from all over the state from angry and confused beneficiaries. The Task Force focused upon not only the technical adjudicative processing of the claims, but also on how this adjudication process can become more humane and responsive to disability claimants.

From the efforts of this Task Force, now a permanent component of our agency's process, three broad areas of concern can be categorized: (1) Administration, (2) Medical Considerations, (3) The Periodic Review Process. I would like to discuss each of these at this time because these findings parallel the efforts of SSA and Congress in reevaluating the procedures and guidelines under the regulations emanating from the 1980 Amendments. We also note with satisfaction other positive, corrective steps contained in legislation sponsored by our Senior Senator from Pennsylvania and a Member of this Committee, John Heinz.

I. Administration

The findings and recommendations of the Task Force in this area have resulted in a formal implementation plan which gives high priority to a fair, comprehensive and personalized assessment of the claimant's disability. As a result of over 140 personal contacts with claimants, the consistent thread in responses was the depersonalized approach taken with claimants and insensitivity to their problems. Clearly, this is indicative of the need for a more sensitive system.

We in Pennsylvania have initiated a series of steps to improve the adjudicator's awareness of claimant needs. Briefly these are

-- Initiating the adjudicating process begins with a personal claimant contact rather than written notification.

-- All written communications now being sent to claimants have been reviewed and revised so that the claimant can better understand the adjudicative process.

- Uniform procedures are being developed in each of our branch offices to consistently address claimant complaints.
- Questionnaires have been mailed to randomly selected allowed and denied claimants in an effort to evaluate our service delivery system.
- We have developed both initial and in-service training programs to redirect our adjudicators' efforts toward a more personal and comprehensive assessment of the claimant.
- We have instituted a matching system when scheduling consultative exams so that service provider facilities present no architectural barriers for the claimant.

II. Medical Considerations

In the area of medical considerations, we became aware that the Periodic Review Process was detrimental to the overall benefit determination system. Many of the practices and procedures used in initial claim development were injurious to the claimant when applied to the Periodic Reviews. I draw your attention to two areas of concern: (1) the development of medical histories and (2) volume providers.

Medical Histories

During the initial stages of the Task Force activity, the state agencies were advised to adjudicate Periodic Reviews considering current medical evidence. This gave little consideration to the prior years of disability and in particular the impact these considerations would have on the mentally impaired. When only the current status of a psychiatric impairment is evaluated, the history of recurrence and remission cannot be considered. Further, I would point out that a study by the House Select Committee on Aging shows that, while there are more cardiovascular and orthopedically impaired beneficiaries, the mentally impaired were the most frequently terminated by the Periodic Review Process. We believe that this occurs because insufficient consideration is given to prior medical history. A case in point is a fifty-year old widow with a thirty-year history of psychiatric disability and with other lesser physical ailments--arthritis and diabetes--was terminated from the Pennsylvania rolls.

Volume Providers

One measure of an agency's performance is the percentage of cases pending over seventy calendar days. Pennsylvania, when applying this standard to the unprecendented volume of Periodic Review cases, was unable to obtain enough physicians to satisfy consultative examination needs. It was then that the "volume provider" appeared in Pennsylvania, and in several other states, I add, to perform the needed consultative exams associated with the Periodic Review cases.

Considerable controversy arose in Pennsylvania concerning one of these volume providers--Johnson and Byers. In response, we conducted site visits, analyzed and investigated complaint letters, interviewed claimants who had been examined by Johnson and Byers, and reviewed the consultative examination reports submitted by Johnson and Byers.

As a result of our findings, we have implemented the following corrective operational requirements for volume service providers:

-- All volume provider examination sites must be fully accessible.

-- On a day when a provider of consultative examinations schedules fifteen or more consecutive claimants, an agency representative is on-site to assist in responding to questions and concerns of the claimants.

-- To assure the continuing accuracy and reliability of the consultative examinations prepared by volume providers, we conduct a semiannual random sample review of their reports. These reports are reviewed by a staff physician in the same or related specialty to verify the findings.

With the assistance of the Pennsylvania Medical Society, we have involved the medical community by asking for their advice about standards and guidelines to be used in consultative examinations. As a panel, these physicians were asked to provide the agency with comments and recommendations concerning

-- The time which would minimally be required to thoroughly conduct a consultative examination meeting SSA requirements.

- The qualifications of a volume provider's staff in the supportive field of x-ray, pulmonary functions, treadmill, etc.
- The extent to which standardized reports and findings are acceptable as medical evidence.
- Physicians performing consultative examinations outside of their area of specialty.
- The use of resident physicians to provide consultative examinations.

III. The Periodic Review Process

One of the most glaring questions we faced in Pennsylvania was, "Why are people who were granted disability benefits in the past now being terminated by The Periodic Review Process in such large numbers?"

Our Task Force pointed to the 1979 changes to the medical listing used in determining disability as having a significant impact upon the Periodic Review cases. Persons previously found to be disabled under a less restrictive set of listings now find their claims being reexamined using a more "stringent" set of medical listings. For example, for an individual to meet the medical listing of back impairment from nerve root compression under the "old" (prior to 1979) listing, medical evidence had only to show pain and motion limitation in the back or neck. Now to meet the "new" listing, pain and muscle spasm and significant limitation in the spine must be documented.

Another example is that, prior to 1979, to meet the listing for disability following a myocardial infarction (heart attack) evidence was required showing the infarction had occurred and there was chest discomfort. Now, in addition to evidence of the infarction and chest discomfort, the listings require specific exercise test results (treadmill) or specific resting electrocardiogram (EKG) readings.

We also found statistical indications that SSA procedural revisions contributed to the high termination rates associated with the Periodic Reviews. In 1975, 44 percent of the claims allowed were based upon the beneficiary's impairments "equaling" the medical listings. The revised SSA administrative policies had reduced this allowance category to 9 percent by 1981. SSA now discourages the allowance of claims where an impairment is similar in severity, but not specifically described in the medical listing.

Compounding this issue is that SSA no longer considers the combined effect of all impairments of the individual, but rather evaluates each impairment singularly, resulting in many of the multiply disabled being terminated from the disability rolls.

Consequently, people who were allowed disability benefits and who relied on these payments, in many instances for over ten years, now find their benefits terminated under these more stringent guidelines. Furthermore, many persons' medical conditions have not improved or may even have worsened since their initial allowance. This situation, when combined with many years of nonemployment and deterioration of work sills, has created a large group of angry and vocal disabled citizens. It is this scenario of events which has resulted in an adverse effect on claimants dependent on this system.

Adding to the public anger and confusion about these Periodic Reviews is something I'm sure the Committee is well aware of--the very high rate of reversals by ALJ's of adjudicator decisions. This situation has had the effect of callously pushing already distraught people back and forth--in and out of eligibility. At least a semblance of uniformity in the process could spare these people considerable anguish.

In support of the Social Security Administration, it appears that some of these problems are being recognized and that corrective measures are being taken. In March of 1982, SSA published information designed to improve public understanding of the Periodic Review process by explaining why the claims are being reviewed and how the Review Process works.

SSA, realizing that certain older disabled beneficiaries should not be included in this Review Process, twice revised their selection procedures to screen out beneficiaries over age 62 and also beneficiaries over age 59 with certain impairments.

Additionally, SSA revised its policy to accept medical evidence generated during a twelve-month period for specific chronic disabilities.

Nevertheless, the large volume of Periodic Review cases and the pressure created by processing time goals remain.

The increased workload imposed upon Pennsylvania by the acceleration of these Periodic Reviews has made it impossible to meet SSA's expected processing time requirements. As recently as March 1981, the average caseload per adjudicator in our state was 88. By June of this year, that figure had risen to 125.7. The result has been that it is taking us an average of 210 days to process a Periodic Review. Pennsylvania's recommended time is 120 days for Periodic Review cases.

We estimate that it would take 94 staff members to handle our expected total of 19,344 Periodic Reviews in the current fiscal year and meet the 120-day-per-case recommendation. Currently our complement is authorized at 640 positions of which only 578 are filled because of funding limits. Of the 578 filled positions, 245 are adjudicators and it is estimated an additional 50 are needed to reduce the backlog of Periodic Review cases in the next year.

The remainder is needed to service our regular disability caseload of more than 122,000.

But even if these problems can be solved, there is a more important one which should be addressed if the purging of the Social Security Disability rolls is to be carried out fairly and with sensitivity to human needs.

There is a crying need for some kind of transitional steps for many of those whose benefits will be terminated to ease them from their total dependence on SSA benefits into a new and altered life situation--that of competitive employment.

As an outgrowth of our Task Force report, we have developed a comprehensive medical/vocational model for use at a key point in the Periodic Review Process. The key point is after the initial notice of termination and during the reconsideration of that decision. We will recommend use of this model to SSA.

The major elements of the model are:

* An in-depth interview to obtain a detailed work, education and social history of the person.

* A comprehensive medical evaluation by a certified internist.

* An evaluation of physical capacity done by a licensed occupational therapist under the direction of a physiatrist.

* Vocational and work-sample testing to determine how the individual actually performs in a simulated work setting and if he has skills which could be used in alternative employment.

* Referral to public or private agencies that can best meet the claimant's needs.

We estimate that it will take an individual about fifteen days to complete this medical-vocational evaluation.

These beneficiaries will be given the opportunity to participate in a model program that will more thoroughly assess the medical and vocational elements of their impairments. This evaluation will provide more comprehensive information for their final adjudicative decision. If terminated, the beneficiary, in addition to knowing that their evaluation was complete and thorough, will also have a detailed vocational evaluation to assist in their adjustment to a new life situation.

We are preparing a medical/vocational evaluation proposal which will be completed and forwarded to SSA for review the week of August 23, 1982.

CONCLUSION

In conclusion, Mr. Chairman, I believe that, with the changes I have described, we will make significant strides in achieving, humanely and responsively, the goals I am certain we all share: To insure that the Social Security Disability rolls are free of undeserving beneficiaries; to provide a transition between dependency on the system and the task of finding employment; to guarantee that those with genuinely serious or long-term disabilities continue to receive the help they so badly need.

COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF LABOR AND INDUSTRY
HARRISBURG, PENNSYLVANIA

THE SECRETARY

September 28, 1982

The Honorable John Heinz
United States Senate
443 Russell Building
Washington, D.C. 20510

Dear Senator Heinz:

Thank you for your recent request for further information concerning my August 18, 1982 testimony before the U.S. Senate Finance Committee hearings on Social Security disability.

As I stated at that time, I am pleased that Pennsylvania and Governor Dick Thornburgh were able to respond early to difficulties posed by implementation of the Social Security Amendments of 1980. Since that time both Congress and the Social Security Administration have taken positive steps to re-evaluate the entire process of disability determination.

I am hopeful the enclosed response to your additional questions will further clarify the problems we have encountered in Pennsylvania and will contribute to your endeavors in this critical area.

Thank you again for the opportunity to assist you in this matter. Please do not hesitate to contact me directly if I can be of further assistance.

Sincerely,

Barry H. Stern

1. LAST SPRING, REPRESENTATIVES OF THE GENERAL ACCOUNTING OFFICE (GAO) VISITED THE PENNSYLVANIA STATE DISABILITY DETERMINATION UNIT IN HARRISBURG. SOME OF THE DISABILITY EXAMINERS THEY TALKED TO WERE CRITICAL OF THE CDI PROGRAM. THE EXAMINERS SAID THE WORKLOAD WAS GROWING FASTER THAN THE STAFF, AND THAT THE UNREALISTIC PROCESSING GOALS WERE PRESSURING THEM TO MOVE CASES TOO QUICKLY, AND THAT THE QUALITY OF DECISIONS WAS SUFFERING AS A RESULT. THEY ALSO SAID THE CHANGING SIGNALS FROM THE SOCIAL SECURITY ADMINISTRATION AND THE TIGHTENING OF CRITERIA ARE CAUSING INDIVIDUALS TO BE TERMINATED WHO HAVE NOT IMPROVED AND OFTEN ARE WORSE THAN WHEN THEY WERE AWARDED BENEFITS. COULD YOU ELABORATE ON THESE PROBLEM AREAS IDENTIFIED BY THE DISABILITY EXAMINERS? IN PARTICULAR, COULD YOU EXPLAIN HOW THE BURGEONING CASELOAD HAS HAD AN ADVERSE IMPACT ON THE QUALITY OF DECISIONMAKING?

The concern you express regarding the "burgeoning workload" and its affect on the quality of decisionmaking in the periodic review was identified by the Pennsylvania Task Force on Bureau of Disability Determination (BDD) in its final report. The Task Force felt the processing time goals imposed on the state agencies were unattainably high. Prior to the periodic reviews our adjudicators caseload averaged 88 claims. Now with these added claims, this figure has risen to an average of 125 claims per adjudicator. Pennsylvania has not received the necessary funding from SSA to hire and train additional staff to adequately deal with this increase. Therefore, to alleviate pressure on our existing staff, the periodic review cases have been allowed to backlog. We now have a backlog of over 7,800 periodic review cases awaiting action.

In addition, as indicated in my testimony, the lack of sufficient lead time to train staff and the lack of specific guidelines for adjudicating claims of this type have created a strain on the system. All of these facts, when combined with a "tighter" set of medical listings and a "stricter" adjudicative climate imposed on the state agencies by SSA, have created a system that is not responsive to the needs of the handicapped citizen.

2. HOW MANY PSYCHIATRISTS ARE EMPLOYED BY THE PENNSYLVANIA STATE DISABILITY DETERMINATION AGENCIES? AND, WHERE PSYCHIATRISTS ARE NOT EMPLOYED, WHO EVALUATES THE PSYCHIATRIC EVIDENCE FURNISHED BY CONSULTATIVE AND TREATING PHYSICIANS?

At the present time there are approximately two hundred (200) psychiatrists or neuro-psychiatrists providing needed consultative examinations in Pennsylvania. Unfortunately, no psychiatrists are employed as full or part-time staff consultants with Pennsylvania BDD. The medical relations staff at BDD has tried with little success to interest psychiatrists in serving as staff consultants. However, we are hopeful that with the assistance of the Medical Review Panel currently working on recommendations for the consultative examination process, peer influence will develop new interest among psychiatrists in working as staff consultants for BDD.

COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF LABOR AND INDUSTRY
HARRISBURG, PENNSYLVANIA 17120

THE SECRETARY

September 8, 1982

Honorable William L. Armstrong
United States Senate
Committee on Finance
2227 Dirksen Senate Office Building
Washington, D.C. 20510

ATTENTION: Robert Lighthizer
Chief Counsel

Dear Senator Armstrong:

I welcome this opportunity to answer the additional questions which you presented in your letter of August 20, 1982. I believe these responses will further clarify Pennsylvania's position related to the problems created by the periodic reviews in our Commonwealth.

Again, my thanks to the Committee for the opportunity to present Pennsylvania's views on this issue.

Sincerely,

Barry H. Stern

1. ACCORDING TO YOUR STATEMENT, WHEN A PROVIDER SCHEDULES 15 OR MORE CONSECUTIVE CONSULTATIVE EXAMINATIONS AN AGENCY REPRESENTATIVE IS AVAILABLE TO ANSWER CLAIMANT QUESTIONS. MORE THAN 15 EXAMS PER DAY MEANS THAT LESS THAN 30 MINUTES IS AVAILABLE FOR EACH EXAMINATION. CAN A FULL EVALUATION BE COMPLETED IN THAT SHORT OF TIME?

Your concern regarding the completeness of a 30 minute examination is one that was shared by the Pennsylvania Task Force on the Bureau of Disability Determination (BDD). As recommended in the task force report, a panel of medical experts is currently reviewing the consultative examination process used in Pennsylvania BDD. One of the questions being addressed by the panel is the amount of time needed to thoroughly conduct a consultative examination while still meeting the Social Security Administration (SSA) requirements. As indicated in my statement, Pennsylvania BDD is monitoring all providers of consultative examinations scheduling 15 or more examinations per day. While it does appear that this allows only 30 minutes per examination, most providers do have a team of more than one physician providing examinations on any given day, thus allowing a physician more than 30 minutes per exam. Also, it is realized that certain consultative examinations require more time to complete than others.

2. IN YOUR OPINION, IS THE CURRENT CESSATION RATE OF 44 PERCENT IN PENNSYLVANIA THE RESULT OF THE INCREASED WORKLOAD IMPOSED BY PERIODIC REVIEWS?

In my opinion, the cessation rate is not a reflection of the workload imposed by periodic reviews. Rather it is a reflection of the types of claims we are asked to review. SSA applies a screening process to potential Continuing Disability Investigations (CDI) to identify those claims which are most likely to be continued. This screening is based upon the severity of impairment, age, education and similar criteria. These claims are not sent to the State agency for adjudication. Rather the claims sent to the State agency are those that do not meet the screening criteria and therefore include a higher percentage of claims likely to be ceased or terminated. In Pennsylvania, to minimize the impact of this increased CDI workload on our adjudication staff, a backlog of approximately 10,000 unassigned CDI claims has been accumulating. We feel this action is necessary to allow our staff adequate time to adjudicate the claims thoroughly and accurately, and at the same time, avoid any suggestion of a numerical goal for cessations or continuations.

3. FUNDING LIMITS ALLOW YOU TO FILL ONLY 578 OF 640 AUTHORIZED POSITIONS ACCORDING TO YOUR STATEMENT. WHO IMPOSED THOSE LIMITS? IS IT THAT SSA OR THE STATE WILL NOT FUND ALL 640 POSITIONS?

While it is true SSA has authorized 640 positions, to date SSA has not provided additional funding to hire the staff necessary to reach that 640 figure.

4. A FREQUENT CRITICISM IS THAT THE HIGH RATE AT WHICH ADMINISTRATIVE LAW JUDGES (ALJ) REVERSE STATE AGENCY DECISIONS (60-65% OF CASES) REVEALS POOR DECISION-MAKING AT THE STATE AGENCY LEVEL. DO YOU BELIEVE THAT ALJ'S -- UNDER COMPARABLE WORKLOAD PRESSURE -- MAKE BETTER DECISIONS? WHY?

I do not believe the high reversal rate of the ALJ's is indicative of poor decisions at the State agency level. ALJ's make their decisions based upon their interpretation of medical and vocational evidence and are guided by Federal appeals court interpretations of the disability laws. Also, ALJ's have an opportunity for a face-to-face contact with the claimant at which time subjective information such as pain can be presented. The State agency on the other hand is not allowed by current SSA regulations to consider pain as an element in the adjudication process. In addition, frequently the ALJ is provided with medical evidence that was unavailable to the State agency at the time of their decision.

Senator **Armstrong**. Senator Heinz, I explained a few moments ago that we are now operating under fairly close time constraints, but I would be happy to recognize you if you have questions that you would like to address.

Senator **Heinz**. Thank you, Mr. Chairman.

I particularly want to thank Mr. Stern for his work and the work of the Department on the comprehensive vocational and medical evaluation model, which sounds very creative and very hopeful. Let me just encourage you in what you are doing. It may be a very meaningful way out of the wilderness for a very large number of people.

I have one question which I am going to direct to Secretary Stern:

Probably the single biggest issue in contention between the House bill, between the administration and some of us here, is whether or not there should be a standard of redetermination based on medical improvement.

Let's take the easiest example of that that I know of which is the provision in my bill, S. 2731, where medical improvement takes into consideration advances in medical technology. Now, those vary by area.

For example, in some medical areas there hasn't been much in the way of advancement, and in others there has been a considerable amount.

Do you think that we should mandate such a medical technology standard?

Mr. **Stern**. It is hard to mandate within four corners a specific standard. What I think can happen, though, because of medical advances that are constantly happening, is that where it is applicable and where this individual can meet the criteria that I have just described in our evaluation model, that maybe within those constraints an individual should be terminated.

In order to ease that, though, I was talking about the transitional period, as you speak of in your legislation also, that would be able to determine if and when this person can lose his or her dependence on these benefits.

One of the most traumatic experiences that we are seeing in Pennsylvania is that for those that are being terminated now, it's because of a detrimental reliance, in their minds, on these benefits, and with a "callous" purging from the rolls.

Senator HEINZ. I think your point is extremely well taken. As I understood your first answer — and correct me if I am wrong—you do not favor people being terminated whose medical conditions have gotten worse or have stayed the same; but you are not quite sure on what standard we should apply that test. Is that correct?

Mr. STERN. Absolutely. Those whose conditions are the same or worse I don't believe should be terminated unless adequate measures are taken to ease them back into the environment from which they came.

Senator HEINZ. Thank you.

Senator ARMSTRONG. Thank you, gentlemen. We appreciate your participation.

Next we will hear from Mr. Edwin O. Opheim and Mr. Nelson Weinstock.

Mr. Opheim is assistant commissioner of the Minnesota Division of Vocational Rehabilitation of the Department of Economic Security in St. Paul, Minn.

Mr. Weinstock is deputy commissioner of operations from the New York State Department of Social Services.

Mr. Opheim, we are going to get you on that last plane to St. Paul yet, and we appreciate your patience; but I am under firm instructions from Senator Durenberger that we are to meet your travel schedule. We are glad to be able to do that.

Senator DURENBERGER. Mr. Chairman, not to delay his airplane——

Senator ARMSTRONG. Oh, I beg your pardon. I didn't see that you had returned. I thought you were not in the room.

Senator DURENBERGER. Let me express my appreciation to you for your thoughtfulness, and to the chairman of the full committee.

About Ed, I just want to say one of the reasons he is here is not just that he is from Minnesota. He has been involved in vocational rehabilitation most of his life, and for the last couple of years at least he has been a key member of a task force that I have had in Minnesota to deal strictly with the issue of disability.

One of our early contributions out of that group related to work incentives for disabled persons, and a lot of recommendations, some of which probably appear in his full statement, and some of which appear in the bill which Senator Heinz and I have cosponsored. Under a previous administration Ed was a member of the National Council on the Handicapped, as well, and so I recommend his testimony to members of the subcommittee.

Senator ARMSTRONG. Thank you, Senator Durenberger.

Mr. Opheim, please proceed.

STATEMENT OF EDWIN O. OPHEIM, ASSISTANT COMMISSIONER, MINNESOTA DIVISION OF VOCATIONAL REHABILITATION, DEPARTMENT OF ECONOMIC SECURITY, ST. PAUL, MINN.

Mr. OPHEIM. Mr. Chairman and members of the Finance Committee, I appreciate very much this opportunity to present my views on the Social Security Disability Amendments and to comment on the impact of the current policies as they relate to this program.

I have with me Mr. Wally Roers, who is the assistant director of the disability insurance program in the State of Minnesota, and I may call on him to comment on some certain aspects of the testimony.

My name is Ed Opheim. I am the director of the Minnesota vocational rehabilitation program, which is a division of the Minnesota Department of Economic Security. The vocational rehabilitation program, under a contract with the Social Security Administration, administers the disability insurance program in the State of Minnesota. I have served with the Minnesota DVR for the past 25 years, and as such I have a very definite or a specific interest in the administration and management of this program as well as the disability insurance program.

My main concern is that the periodic continuing disability investigations, as I see them, cannot be administered fairly or effectively under the current provisions that are in place. The result of the application of these provisions as they exist is such that the lives of handicapped persons throughout this country are being adversely affected, and in many instances unfairly so. I would like to describe for you some real life examples of how this is happening or occurring. I would first like to provide some information on the size and scope of the activity of the disability insurance program in Minnesota.

Earlier members of the various panels talked about the cessation rate of disability recipients throughout the country. I think they talked about a cessation rate of 44.4 percent during this past year. In the Minnesota agency we have had during the same time period almost 1300 cessations. The rate of cessation was 30.5 percent—considerably less than the national average. In spite of the cessation rate being considerably less than the national average, we are still faced with some very serious problems in the State.

I think when people are losing benefits in such massive numbers throughout the Nation, there are obvious questions which arise: Are the people losing benefits truly employable? Who are the people who have been most affected by this process? Have the decisions been accurate? Is there a need to further reform the process of review?

I would like to discuss two specific cases which were handled by the Minnesota State agency, and I believe these cases illustrate two aspects of the termination process or results.

The first case is an example of an individual who should not have been collecting disability payments and was properly reviewed and subsequently had his benefits ceased. The individual is 38 years old and had been collecting benefits for 10 years. He was initially found disabled due to a back injury sustained while working as a police officer. This man collected monthly benefits for 10 years and never underwent any review in regard to his eligibility until the periodic review began in 1981. At that time the medical evidence revealed that individual had no objective medical findings of disability, he had no neurological defects, no muscle wasting, and no significant X-ray findings of pathology. At age 38, with a high school education and no findings of any signficant impairment, it was determined that this man should no longer collect disability benefits. The decision was subsequently upheld by both the Administrative Law Judge and the appeals council. I believe this claim illustrates the importance of the periodic review process when it is properly applied, and it underscores the need not to abandon such a process.

This man, however, still has many problems. We have been confirming his inability to work for ten years through benefit payments. He has adjusted his whole life style and that of his family to that disability income. It may take him much more than the three months his benefits will be continued to readjust to employability even with the best of vocational rehabilitation services.

The second case I would like to discuss concerns an individual who had been receiving benefits for a period of 7 years due to schizophrenia. In February of 1982 this woman's claim was investigated as a periodic case review. The medical findings at that time, including a psychiatric consultative examination, revealed an individual with a severe psychiatric problem. Among other findings, the case file reveals that this woman was tearful during examination, literally consumed with concern about a pet cat dying of leukemia. She was described as becoming easily confused when attempting to listen to people, and being unable to distinguish between her dreams and reality.

The examining psychiatrist described her fears of going outside her home as being close to delusional. In concluding his examination, the examining psychiatrist stated the following:

> The patient has problems relating to others because she doesn't listen, gets confused, does not know what is real or unreal. Her attention is scattered, and she doesn't seem to focus on any one thing very well, except she seems to be able to meet the needs of her cats as far as I can determine. From her history it appears that she is unable to do much of anything because of her mental impairment.

The above woman's benefits ceased as of February 1982 on the basis that she would be capable of performing simple, unskilled work.

This benefit cessation was dictated by the adjudication standards currently in use. This case, I believe, is an illustration of the review process not working as it should.

This woman will not return to employment, and yet using today's very rigid adjudication standards she was properly found not eligible for disability benefits. I believe that this raises a significant question about the standards in use today.

The cases that I have discussed illustrate both the need to continue a review process, but at the same time to improve the system so that the decisions are the most equitable possible. Of particular concern, as Congress has pointed out, are those applicants who suffer from mental illness or mental retardation. These individuals are of particular concern not only because of the nature of the impairment but also because of the great percentage of decisions which involve mental illness and mental retardation. Experience in our agency shows that between March of 1981 and February of 1982, 46 percent of all cessations involved people with mental illness. I believe that this group particularly is being hurt by excessively rigid standards that do not reasonably differentiate the employable from the unemployable.

One other major issue in regard to the periodic review process is the effect such a process has on the administration of the State agencies.

In the State of Minnesota the staff of the disability unit has increased from 103 employees to 152 employees in less than 2 years. This is a 47-percent increase in staff that is required to do the job. This staff increase was due almost exclusively to the periodic review process.

This expansion that we have had within the agency, coupled with the additional caseload, has created a signficant strain. The experienced examiners in the agency have caseloads which are almost exclusively comprised of periodic continuing disability investigation claims.

The experienced staff spends 80 percent of their time working on periodic review claims; newer examiners have been brought on board in the last year and are responsible for processing the majority of the initial claims. The agency has been able to maintain the accuracy of the decisions, but it is no longer able to process the initial claims within the time standards established by the Social Security Administration.

In view of the national importance and the serious problems associated with the periodic review process, I believe that an immediate moratorium of the periodic review process should be considered. I believe this moratorium should not extend to those cases which were diaried for continuing disability investigation on the basis of anticipated improvement, but only on the periodic reviews. Such a moratorium would allow the State agencies time to devote needed attention to initial claims which are presently delayed in processing because of the huge caseload of periodic reviews. It would also provide time for a study of the disability standards in use to determine their relationship to real employability. Furthermore, it is felt that such a moratorium should continue until such time as legislative changes in the periodic review process have been completed, and necessary lead time can be given to the State agencies to implement such changes.

Mr. Chairman and members of the committee, if anyone were to ask me if this program was a failure, my response would be, No, it is not a failure. However, I would be the first to point out that in 1982 we are living with a legacy of prior decisions reaching back at least a decade. Decisions that were made under standards that are no longer in use today. It is essential and proper to undertake this national examination of continuing eligibility for disability insurance. I believe that it is necessary that we focus our consideration in that direction; however, I also believe that the process of reexamination must move forward in the most fiscally responsible and humane direction.

In summary, it is my observation that the periodic review process is essential to the effective and equitable administration of the disability insurance program, but it is not working as it was intended.

I respectfully offer two suggestions for your consideration:

First, that an immediate moratorium be placed on the periodic review process. This would immediately halt the injustices presently occurring and would allow time to find appropriate solutions to the problems inherent in the current system.

Second, a continuation of this hearing in the form of several additional meetings to explore in depth the impact of current legislative proposals in order to assure a long-term solution to the problems that exist in the current system.

Several proposals now being considered for reform of the periodic review process, while appearing valid on the surface, need to be thoroughly examined to insure that they will lead to the intended result.

Senator ARMSTRONG. Thank you, Mr. Opheim.

[The prepared statement of Edwin O. Opheim follows:]

TESTIMONY STATEMENT ON THE SOCIAL SECURITY DISABILITY INSURANCE PROGRAM

PRESENTED BY

EDWIN O. OPHEIM

DIRECTOR OF THE MINNESOTA VOCATIONAL REHABILITATION PROGRAM

BEFORE THE

SENATE FINANCE COMMITTEE OF THE UNITED STATES CONGRESS

WEDNESDAY, AUGUST 18, 1982

2 P.M.

MR. CHAIRMAN AND MEMBERS OF THE U.S. SENATE FINANCE COMMITTEE:

I APPRECIATE THIS OPPORTUNITY OF PRESENTING MY VIEWS ON THE SOCIAL SECURITY DISABILITY INSURANCE PROGRAM AND TO COMMENT ON THE IMPACT OF CURRENT POLICIES AS THEY RELATE TO THIS PROGRAM.

MY NAME IS EDWIN OPHEIM, AND I AM THE DIRECTOR OF THE MINNESOTA VOCATIONAL REHABILITATION PROGRAM, A DIVISION OF THE MINNESOTA DEPARTMENT OF ECONOMIC SECURITY. THE VOCATIONAL REHABILITATION DIVISION, UNDER CONTRACT WITH THE SOCIAL SECURITY ADMINISTRATION, ADMINISTERS THE DISABILITY INSURANCE AGENCY IN THE STATE OF MINNESOTA. I HAVE SERVED WITH THE MINNESOTA DIVISION OF VOCATIONAL REHABILITATION FOR THE PAST TWENTY-FIVE YEARS, WITH THE LAST SIXTEEN IN AN ADMINISTRATIVE CAPACITY AND FOR THE PAST THREE YEARS HAVE BEEN THE DIRECTOR OF THE PROGRAM. AS SUCH, I HAVE A PROFESSIONAL INTEREST IN THE MANAGEMENT AND CONDUCT OF THE SOCIAL SECURITY DISABILITY INSURANCE PROGRAM. I ALSO HAVE A VERY PERSONAL INTEREST IN THE PROBLEMS OF HANDICAPPED PERSONS, BEING THE PARENT OF A SIXTEEN-YEAR OLD DAUGHTER WITH CEREBRAL PALSY AND HAVING A MODERATE HEARING IMPAIRMENT MYSELF.

MY MAJOR CONCERN CENTERS AROUND THE IMPACT OF REGULATIONS AND POLICIES PRESENTLY GOVERNING THE CONTINUING DISABILITY INVESTIGATION (CDI) ASPECTS OF THE DISABILITY INSURANCE PROGRAM, PARTICULARLY THE PERIODIC REVIEWS MANDATED BY THE 1980 SOCIAL SECURITY AMMENDMENTS.

MY PROFESSIONAL CONCERN IS THAT THE PERIODIC CONTINUING DISABILITY INVESTIGATIONS CANNOT BE ADMINISTERED FAIRLY OR EFFECTIVELY UNDER THE CURRENT PROVISIONS THAT ARE IN PLACE. MY PERSONAL CONCERN IS THAT THE CURRENT STATUS OF THE DISABILITY INSURANCE PROGRAM IS SUCH THAT THE

LIVES OF HANDICAPPED PERSONS THROUGHOUT THIS COUNTRY ARE BEING ADVERSELY AFFECTED AND, IN MANY INSTANCES, UNFAIRLY SO. I WOULD LIKE TO DESCRIBE FOR YOU SOME REAL LIFE EXAMPLES OF HOW THIS IS HAPPENING. HOWEVER, I WOULD FIRST LIKE TO PROVIDE SOME INFORMATION ON THE SIZE AND SCOPE OF ACTIVITY OF THE DISABILITY INSURANCE PROGRAM IN MINNESOTA.

THE IMPORTANCE AND THE ENORMITY OF THE PERIODIC REVIEW PROCESS CAN READILY BE SEEN FROM THE STATISTICS CONCERNING THE NUMBER OF PEOPLE REVIEWED AND THE DECISIONS MADE TO CEASE BENEFITS IN THE PAST YEAR. FROM MAY 1, 1981 UNTIL MAY 28, 1982 NATIONWIDE 106,862 DISABILITY RECIPIENTS HAD THEIR BENEFITS CEASED UNDER THIS PROGRAM. THE NATIONAL RATE OF CESSATION HAS BEEN 44.4 PERCENT DURING THIS PAST YEAR. IN THE STATE OF MINNESOTA DURING THIS SAME TIME PERIOD, 1,278 CESSATIONS WERE PROCESSED. THE MINNESOTA RATE OF CESSATION WAS 30.5 PERCENT, CONSIDERABLY LESS THAN THE RATE OF CESSATION NATIONWIDE. WITH PEOPLE LOSING BENEFITS IN SUCH MASSIVE NUMBERS ON A NATIONAL SCALE, THERE OBVIOUS QUESTIONS WHICH HAVE ARISEN. ARE THE PEOPLE LOSING BENEFITS TRULY EMPLOYABLE? WHO ARE THE PEOPLE WHO HAVE BEEN MOST AFFECTED BY THIS PROCESS? HAVE THE DECISIONS BEEN ACCURATE? IS THERE A NEED TO FURTHER REFORM THE PROCESS OF REVIEW?

IN AN ATTEMPT TO ANSWERE SOME OF THESE QUESTIONS, I WOULD LIKE TO DISCUSS TWO SPECIFIC CASES WHICH WERE HANDLED BY THE MINNESOTA STATE AGENCY. I BELIEVE THESE CASES ILLUSTRATE TWO EXTREMES. THE FIRST CASE IS AN EXAMPLE OF AN INDIVIDUAL WHO SHOULD NOT HAVE BEEN COLLECTING DISABILITY PAYMENTS, AND WAS PROPERLY REVIEWED AND SUBSEQUENTLY HAD HIS BENEFITS CEASED. THIS INDIVIDUAL IS 38 YEARS OLD AND HAD BEEN

COLLECTING BENEFITS FOR TEN YEARS. HE WAS INITIALLY FOUND DISABLED DUE TO A BACK INJURY SUSTAINED WHILE WORKING AS A POLICE OFFICER. THIS MAN COLLECTED MONTHLY BENEFITS FOR TEN YEARS AND NEVER UNDERWENT ANY REVIEW IN REGARD TO HIS ELIGIBILITY UNTIL THE PERIODIC REVIEW BEGAN IN 1981. AT THAT TIME THE MEDICAL EVIDENCE REVEALED THAT THIS INDIVIDUAL HAD NO OBJECTIVE MEDICAL FINDINGS OF DISABILITY. HE HAD NO NEUROLOGIC DEFECTS, NO MUSCLE WASTING, AND NO SIGNIFICANT X-RAY FINDINGS OF PATHOLOGY. AT AGE 38, WITH A HIGH SCHOOL EDUCATION AND NO FINDINGS OF ANY SIGNIFICANT IMPAIRMENT, IT WAS DETERMINED THAT THIS MAN SHOULD NO LONGER COLLECT DISABILITY BENEFITS. THIS DECISION WAS SUBSEQUENTLY UPHELD BY BOTH THE ADMINISTRATIVE LAW JUDGE AND THE APPEALS COUNCIL. I BELIEVE THIS CLAIM ILLUSTRATES THE IMPORTANCE OF THE PERIODIC REVIEW PROCESS WHEN IT IS PROPERLY APPLIED AND IT UNDERSCORES THE NEED NOT TO ABANDON SUCH A PROCESS.

THE SECOND CASE I WOULD LIKE TO DISCUSS CONCERNS AN INDIVIDUAL WHO HAD BEEN RECEIVING BENEFITS FOR A PERIOD OF 7 YEARS DUE TO SCHIZOPHRENIA. IN FEBRUARY OF 1982 THIS WOMAN'S CLAIM WAS INVESTIGATED AS A PERIODIC CASE REVIEW. THE MEDICAL FINDINGS AT THAT TIME, INCLUDING A PSYCHIATRIC CONSULTATIVE EXAMINATION, REVEALED AN INDIVIDUAL WITH A SEVERE PSYCHIATRIC PROBLEM. AMONG OTHER FINDINGS, THE CASE FILE REVEALS THAT THE WOMAN WAS TEARFUL DURING EXAMINATION, LITERALLY CONSUMED WITH CONCERN ABOUT A PET CAT DYING OF LEUKEMIA. SHE WAS DESCRIBED AS BECOMING EASILY CONFUSED WHEN ATTEMPTING TO LIST TO PEOPLE, AND BEING UNABLE TO DISTINGUISH BETWEEN HER DREAMS AND REALITY. THE EXAMING PSYCHIATRIST DESCRIBED HER FEARS OF GOING OUTSIDE HER HOME AS BEING CLOSE TO DELUSIONAL. IN CONCLUDING HIS EXAMINATION, THE EXAMING PSYCHIATRIST STATED THE FOLLOWING: "THE PATIENT HAS PROBLEMS RELATING

TO OTHERS BECAUSE SHE DOESN'T LISTEN, GETS CONFUSED, DOESN'T KNOW WHAT IS REAL OR UNREAL. HER ATTENTION IS SCATTERED AND SHE DOESN'T SEEM TO FOCUS ON ANY ONE THING VERY WELL, EXCEPT SHE SEEMS TO BE ABLE TO MEET THE NEEDS OF HER CATS AS FAR AS I CAN DETERMINE. FROM HER HISTORY IT APPEARS THAT SHE IS UNABLE TO DO MUCH OF ANYTHING BECAUSE OF HER MENTAL IMPAIRMENT."

THE ABOVE WOMAN'S BENEFITS WERE CEASED AS OF FEBRUARY, 1982 ON THE BASIS THAT SHE WOULD BE CAPABLE OF PERFORMING SIMPLE, UNSKILLED WORK. THIS CASE, I BELIEVE, IS AN ILLUSTRATION OF THE REVIEW PROCESS NOT WORKING AS IT WAS INTENDED. THIS IS TYPICAL OF THE CESSATIONS WHICH HAVE CAUSED NATIONAL CONCERN--SOMEONE WHO HAS COLLECTED AND DEPENDED ON DISABILITY PAYMENTS FOR YEARS, WHO HAS NOT APPROVED MEDICALLY, WAS NEVER AWARE THAT HER CLAIM WOULD BE INVESTIGATED, AND WAS GRANTED BENEFITS UNDER STANDARDS WHICH NO LONGER EXIST. AND FEW PEOPLE, I THINK WOULD DISAGREE THAT SHE IS DESERVING OF DISABILITY PAYMENTS. THIS POINTS OUT THE PROBLEM WITH THE CURRENT STANDARDS AND THE GRAVE CONSEQUENCES WHEN THESE STANDARDS ARE APPLIED TO LONG TERM RECIPIENTS THROUGH THE PERIODIC REVIEW PROCESS.

THE CASES DISCUSSED ABOVE, IT SEEMS CLEAR, ILLUSTRATE BOTH THE NEED TO CONTINUE A REVIEW PROCESS BUT AT THE SAME TIME IMPROVE THE SYSTEM SO THAT THE DECISIONS ARE THE MOST EQUITABLE POSSIBLE. OF PARTICULAR CONCERN, AS CONGRESS HAS POINTED OUT, ARE THOSE APPLICANTS WHO SUFFER FROM MENTAL ILLNESS OR MENTAL RETARDATION. THESE INDIVIDUALS ARE OF PARTICULAR CONCERN NOT ONLY BECAUSE OF THE NATURE OF THEIR IMPAIRMENT, BUT ALSO BECAUSE OF THE GREAT PERCENTAGE OF DECISIONS WHICH INVOLVE MENTAL ILLNESS AND MENTAL RETARDATION. EXPERIENCE IN THE

Minnesota State Agency shows that between March of 1981 and February of 1982, 46 percent of all cessations involved people with mental illness.

One further major issue in regard to the Periodic Review Process is the effect such a process has had on the administration of the state agencies. In the state of Minnesota the staff of the Disability Unit has increased from 103 employees to 152 in less than two years. This staff increase was due largely to the Periodic Review Process. This rapid expansion, coupled with the additional caseload on the agency of nearly 7,000 claims, has caused a severe strain on the resources of the agency, as well as the medical community upon whom they must rely for information upon which to make their decisions. The experienced examiners in the agency have caseloads which are almost exclusively comprised of Periodic Continuing Disability Investigations claims. While the experienced staff spends 80 percent of its time working on Periodic Review claims, the newer examiners brought on board in the last year or so are responsible for processing the majority of initial claims. The agency has been able to maintain the accuracy of the decisions but it is taking longer to process the initiail claims. At this time it is unable to meet the time standards prescribed by the Social Security Administration in view or the national importance and the serious problems of the current Periodic Review Process, an immediate moratorium should be considered. This moratorium, I believe should not extend to those cases which were diaried for Continuing Disability Investigation on the basis of anticipated improvement, but only on the Periodic reviews. Such a moratorium would allow the state agencies time to devote needed attention to the initial claims which are presently delayed in processing

BECAUSE OF THE HUGE CASELOAD OF PERIODIC REVIEWS. FURTHERMORE, IT IS FELT THAT SUCH A MORATORIUM SHOULD CONTINUE UNTIL SUCH TIME AS LEGISLATIVE CHANGES IN THE PERIODIC REVIEW PROCESS HAVE BEEN COMPLETED AND NECESSARY LEAD TIME CAN BE GIVEN TO THE STATE AGENCIES TO IMPLEMENT SUCH CHANGES.

MR. CHAIRMAN, MEMBERS OF THE COMMITTEE: IF ONE WERE TO ASK ME IF THIS PROGRAM WAS A FAILURE, MY RESPONSE WOULD BE A DEFINITE "NO." HOWEVER, I WILL BE THE FIRST TO POINT OUT TO YOU THAT IN 1982 WE ARE LIVING WITH A LEGACY OF PRIOR DECISIONS REACHING BACK AT LEAST A DECADE. IT IS ESSENTIAL AND PROPER TO UNDERTAKE THIS NATIONAL EXAMINATION OF CONTINUING ELIGIBILITY FOR DISABILITY INSURANCE. I BELIEVE IT IS NECESSARY THAT WE FOCUS OUR CONSIDERATION AND EFFORT IN THAT DIRECTION.

HOWEVER, I ALSO BELIEVE THAT THIS PROCESS OF REEXAMINATION MUST MOVE FORWARD IN THE MOST FISCALLY RESPONSIBLE AND HUMANE DIRECTION.

SEVERAL PROPOSALS NOW BEING CONSIDERED FOR REFORM OF THE PERIODIC REVIEW PROCESS, WHILE APPEARING VALID ON THE SURFACE, NEED TO BE THOROUGHLY EXAMINED TO INSURE THAT THEY WILL LEAD TO THE INTENDED RESULTS.

IN SUMMARY, IT IS MY OBSERVATION THAT THE PERIODIC REVIEW PROCESS IS ESSENTIAL TO THE EFFECTIVE AND EQUITABLE ADMINISTRATION OF THE DISABILITY INSURANCE PROGRAM -- BUT -- IT IS NOT WORKING AS IT WAS INTENDED.

I RESPECTFULLY OFFER TWO SUGGESTIONS FOR YOUR CONSIDERATION: FIRST, THAT AN IMMEDIATE MORATORIUM BE PLACED ON THE PERIODIC REVIEW PROCESS. THIS WOULD IMMEDIATELY HALT THE INJUSTICES PRESENTLY OCCURRING AND WOULD ALLOW TIME TO FIND APPROPRIATE

SOLUTIONS TO THE PROBLEMS INHERENT IN THE CURRENT SYSTEM.

SECONDLY, A CONTINUATION OF THIS HEARING IN THE FORM OF SEVERAL ADDITIONAL MEETINGS TO EXPLORE IN DEPTH THE IMPACT OF CURRENT LEGISLATIVE PROPOSALS IN ORDER TO ASSURE A LONG-TERM SOLUTION TO THE PROBLEMS THAT EXIST IN THE CURRENT SYSTEM.

THANK YOU, MR. CHARIMAN, FOR GIVING ME THE OPPORTUNITY TO SPEAK BEFORE YOU THIS AFTERNOON.

Senator **ARMSTRONG**. Are there any questions?

I am mindful of your time schedule. I once made it from here to National in 7 minutes, but not at this hour of the day, and I was not at the wheel—I was cringing in the other seat of the car as we careened toward National, and I think you should not attempt to do that.

But are there any observations or questions from the committee before you excuse yourself?

Senator **DURENBERGER**. Just an observation. Bill and I live within 15 miles of the Capitol, and he has been proposing a helicopter service—which I think went out with the Senate gym. That's the only way I think he could get to National in 7 minutes.

Mr. Chairman and members of the committee, also present with us here today is State Representative Janet Clark from Minneapolis, who is a member of the Minnesota State Legislature and who chairs the welfare committee. Yesterday she conducted a hearing in Minnesota on disability. With the Chair's permission, to the degree that you may have a summary of that hearing, and having sat through this entire session today, with the Chair's permission if she might be able to submit a summary of that.

Also with her today are Maureen Billis, who is the staff director for the committee. Maureen's son David is over here, and Representative Clark's daughter is over there.

Senator **ARMSTRONG**. Well, we are delighted to do so, and of course we will be happy to have the results of the hearing in Minnesota.

Mr. **OPHEIM**. Mr. Chairman, I do have a couple of short comments that I would like to make that are not included in my basic testimony.

Senator **DURENBERGER**. You had better submit them in writing, Ed, because I do think you might be running out of time.

[The information was subsequently submitted:]

In addition to the personal injustices and hardships that occur as a result of the current Periodic Review Process, there is a real concern in our state over the resulting transfer of the cost burden to the state and local communities. Yesterday I had the opportunity to attend a special hearing on this issue held by the Health and Welfare Committee of the Minnesota Legislature. During the hearing the Commissioner of Public Welfare expressed grave concern about the transfer of Disability Insurance beneficiaries to General Assistance caseloads, and presented a letter which he had written to the Commissioner of the Social Security Administration stating his concerns. With your permission I would like to introduce a copy of this letter for the record. At this same hearing, a Commissioner of Hennepin County reported that their County Welfare Office employed a full-time staff person to assist Disability Insurance beneficiaries in the development and preparation of their appeal of cessation of benefits. They considered this action necessary to constrain General Assistance costs which were rising as a result of the termination of benefits to persons whom they considered as unemployable.

I have briefly discussed what I view as an urgent need for an immediate temporary moratorium on the Periodic Review Process until the problems inherent in the current system can be remedied. I believe that S.F. 2731 is definitely a step in the right direction. This bill addresses a number of problems which require resolution, and many of the provisions of this bill deserve unqualified support.

There is a provision in the bill which, I believe, should have extensive examination before implementation on a national scale. This is the requirement for a face-to-face hearing at the reconsideration level of appeal.

The intent of this provision is to provide a more thorough and fair decision at the reconsideration level and to prevent the need for many individuals to proceed to the next stage of the appeal before an Administrative Law Judge.

I believe this concept is valid, but I am not fully assured that it will produce the intended results. State agencies are presently required to use the same objective definition and criteria of disability at both the reconsideration and initial level. Unless there is a modification of the standards, which will allow a subjective interpretation of data at the reconsideration level, a face-to-face hearing is likely to produce little, if any, substantial change in reconsideration decisions. If subjective interpretation of evidence is allowable at the reconsideration level, then we are likely to have the same disparity of decision-making within the state agency as we now have between the state agencies and the Administrative Law Judges.

I would respectfully suggest that any face-to-face interview program be thoroughly tested before implementation on a national level. I believe a well constructed pilot study should be conducted in several states before any final decision is made.

Thank you for this opportunity to present these views on the Periodic Review Process of the Disability Determination Program.

Senator ARMSTRONG. Thank you very much.

The committee is pleased to welcome Mr. Nelson Weinstock from New York, from the department of social services there.

Mr. Weinstock?

STATEMENT OF NELSON WEINSTOCK, DEPUTY COMMISSIONER OF OPERATIONS, NEW YORK STATE DEPARTMENT OF SOCIAL SERVICES, MANHATTAN, N.Y.

Mr. WEINSTOCK. Thank you, Mr. Chairman. Thank you for inviting me here today. I am glad most of you have been able to stick around.

I will cut my remarks very short; I realize the hour is late.

You are probably aware that the disability determination function in New York is part of the department of social services, and we operate under contract to the SSA for making medical determinations.

Since the inception of this Federal CDI program, New York State has expressed its concern to Congress and to the Social Security Administration about the massive disruptions and damage to vulnerable individuals that have occurred. While we fully support the goal of assuring that only those beneficiaries who are eligible continue to receive benefits, a program to achieve this goal must be designed with careful attention to its potential impact on recipients and on the public and private agencies designed to assist them. This program has not. Failure to anticipate these consequences has resulted in major hardships for individuals and in administrative nightmares for the States. States performing reviews for SSA are in an untenable position. We are reviewing cases according to Federal guidelines which are unacceptable; however, if States opt not to continue the reviews, clients may receive more superficial reviews resulting in greater numbers of terminations.

The Federal disability program has for some time been considered harsh and restrictive in its rules and regulations. The imposition of the review program has placed a further burden on the disabled population during a period when massive cuts are being made in all programs designed to assist needy and disabled persons.

New York, frankly, is confronted by a problem of major proportions. Since the initiation of the review program in April 1981 over 25,000 New York State residents receiving disability benefits have been reviewed, and more than 11,000 have had their benefits terminated. The Social Security Administration's present plan calls for completion of more than 175,000 disability reviews in New York State by the end of 1984. An additional 175,000 to 200,000 cases receiving SSI title XVI disability benefits are tentatively scheduled for review beginning in late 1983.

Based on SSA's current projections, New York estimates that between 50,000 and 75,000 present recipients of social security disability will have their benefits terminated before the end of 1984. A total of over 100,000 terminations can be expected in the next 5 to 6 years in our State alone.

The hardships experienced by these individuals will be accompanied by fiscal hardship for the State. It is estimated that nearly 60 percent of the title II disability recipients will require some form of State assistance after cessation, involving tens of millions of State and local dollars. When extended to include the title XVI SSI cases, new costs to the State of New York and its counties could exceed $150 million annually. In addition, various State, local, and private service programs that are supported by disability payments will have reduced capacities to provide needed services to the disabled population at a time when they seem to be needing it most. Mental health programs will be particularly affected.

New York's position has been and remains that any review of disability recipients should take every possible action to assure that an appropriate decision is made, that unnecessary injuries are avoided, and that attention is given to providing adjustment assistance to those individuals who will no longer receive benefits.

We believe that this can be accomplished by three actions:

We believe that State disability organizations can do things themselves, and they primarily deal with insuring that quality is appropriate, that the procedures are appropriate, that people who are getting forms understand what those forms mean and what they have to do in order to get their benefits to be continued.

Also, the State programs can do work with the psychiatric community, which is particularly hard-hit in this area, in terms of providing training, in terms of what is required in order to insure that disabilities will continue. And I have included those in my formal statement, so I won't dwell on them.

In addition, though we believe that the major problem with this program is in the definition of disability and the definition of employability, we would suggest the immediate implementation of reforms in the program. Many of them have been mentioned here today, and I will just summarize them quickly:

We would support very strongly a continuation of benefits for needy recipients during an appeal process.

We would support an extension of the period during which claimants can receive benefits after termination to 6 months from the present 3.

We would ask for increased Federal funding—and this is very important—for vocational rehabilitation and other job programs designed to assist former recipients to return to the labor market.

We would ask that the forgiveness of each individual's retroactive claims be continued.

We would ask for an expansion of the representative concept so that people who are going for disability reviews can have assistance in getting through those reviews. It is an extremely complex process.

We would ask that SSA review its time standards and get some of the pressure off the States.

We would ask for increased funding to allow field contact, particularly for psychiatric cases where we believe it is most important.

These suggestions alone, most of which have been mentioned today, will not do the job alone, however. It is critical to recognize that the major problem is caused by the stringency of the definitions of disability and employability.

The Department of Social Services has initiated a study of claimants whose benefits have been terminated and has made an analysis of their characteristics and needs. The preliminary results of this study support our impressions regarding the particularly vulnerable nature of this population. The majority, at best, even though considered disabled, have questionable prospects for employment. This is supported by a finding that in the first 7 months of this program some 25 percent of the terminated clients from title II, people who had worked and had some assets, applied for public assistance. And we expect that that percentage of applications for public assistance will increase significantly.

The Department has also undertaken a review of Federal rules, regulations, and procedures to determine whether they contribute to denials in the decisionmaking process. The results of this review clearly illustrate the exactness and the stringency of the process specified and the severe limitations on the latitude involved in making disability and employability decisions.

The vulnerability of the individuals involved and the stringency of the disability and employability definitions utilized clearly requires Congress and SSA to reexamine the definitions in this program. This is particularly true—and I know this point was made before—when it is recognized that many of the clients who were being ceased were originally qualified for disability under different sets of rules and regulations and procedures than exist today.

In summary, the need for immediate reform in the periodic review program cannot be overstated. Expanded to a nationwide basis, this program could result in termination of benefits for well over 1 million recipients over the next 3 to 5 years.

Our studies have shown that the large numbers of disability recipients whose benefits are terminated cannot reasonably expect to obtain gainful employment and will ultimately require financial assistance from the States.

Faced with greatly diminished resources, States will be unable to meet these pressing needs, and the Nation will be faced with a crisis of major proportions.

[The prepared statement of Nelson Weinstock follows:]

TESTIMONY OF

NELSON WEINSTOCK, DEPUTY COMMISSIONER

DIVISION OF OPERATIONS

NEW YORK STATE DEPARTMENT OF SOCIAL SERVICES

THE NEW YORK STATE DEPARTMENT OF SOCIAL SERVICES HAS PARTICIPATED WITH THE SOCIAL SECURITY ADMINISTRATION (SSA) IN THE SOCIAL SECURITY DISABILITY PROGRAM SINCE ITS INCEPTION IN 1956. THE STATE'S OFFICE OF DISABILITY DETERMINATIONS BASED IN NEW YORK CITY PERFORMS, UNDER CONTRACT FOR SSA, THE MEDICAL DETERMINATIONS NECESSARY TO ADJUDICATE APPLICATIONS FOR TITLE II AND TITLE XVI DISABILITY BENEFITS. THE OFFICE OPERATES UNDER A SET OF RULES, REGULATIONS, AND GUIDELINES DEVELOPED AND PROMULGATED BY THE SOCIAL SECURITY ADMINISTRATION.

IN 1980, CONGRESS PASSED AN AMENDMENT TO THE SOCIAL SECURITY ACT WHICH CALLED FOR A REVIEW OF THE CONTINUED ELIGIBILITY OF EVERY RECIPIENT OF SOCIAL SECURITY DISABILITY BENEFITS. SINCE THE INCEPTION OF THIS FEDERALLY INITIATED PROGRAM, NEW YORK STATE HAS EXPRESSED ITS CONCERN TO CONGRESS AND TO THE SOCIAL SECURITY ADMINISTRATION ABOUT THE MASSIVE DISRUPTIONS AND DAMAGE TO VULNERABLE INDIVIDUALS THAT HAVE OCCURRED. WHILE WE FULLY SUPPORT THE GOAL OF ASSURING THAT ONLY THOSE BENEFICIARIES

WHO ARE ELIGIBLE CONTINUE TO RECEIVE BENEFITS, A PROGRAM TO ACHIEVE THIS GOAL MUST BE DESIGNED WITH CAREFUL ATTENTION TO ITS POTENTIAL IMPACT ON RECIPIENTS AND ON THE PUBLIC AND PRIVATE AGENCIES DESIGNED TO ASSIST THEM. FAILURE TO ANTICIPATE THESE CONSEQUENCES HAS RESULTED IN HARDSHIPS FOR INDIVIDUALS AND IN ADMINISTRATIVE NIGHTMARES FOR THE STATES. STATES PERFORMING REVIEWS FOR SSA ARE IN AN UNTENABLE POSITION. THEY ARE REVIEWING CASES ACCORDING TO FEDERAL GUIDELINES, WHICH ARE UNACCEPTABLE; HOWEVER, IF STATES OPT NOT TO CONTINUE THE REVIEWS, CLIENTS MAY RECEIVE MORE SUPERFICIAL REVIEWS, RESULTING IN GREATER NUMBERS OF TERMINATIONS.

THE FEDERAL DISABILITY PROGRAM HAS FOR SOME TIME BEEN CONSIDERED HARSH AND RESTRICTIVE IN ITS RULES AND DEFINITIONS. THE IMPOSITION OF THE REVIEW PROGRAM HAS PLACED A FURTHER BURDEN ON THE DISABLED POPULATION DURING A PERIOD WHEN MASSIVE CUTS ARE BEING MADE IN ALL PROGRAMS DESIGNED TO ASSIST NEEDY AND DISABLED PERSONS

New York is confronted by a problem of major proportions. Since the initiation of the review program in April 1981, over 25,000 New York State residents receiving disability benefits have been reviewed and more than 11,000 have had their benefits terminated or are in the process of having this occur. The Social Security Administration's present plan calls for completion of more than 175,000 disability recipient reviews in New York State by the end of 1984. An additional 175,000 to 200,000 cases receiving Supplemental Security Income (Title XVI) disability benefits are tentatively scheduled to be reviewed beginning in late 1983.

Based on SSA's current projections, New York estimates that between 50,000 and 75,000 present recipients of Social Security Disability will have their benefits terminated before the end of 1984. A total of well over 100,000 terminations can be expected over the next five to six years.

The hardships experienced by these individuals will be accompanied by fiscal hardship for the State. It is estimated that nearly 60 percent of Title II Disability recipients will require some form of State assistance after cessation, involving tens of millions of State and local dollars. When extended to include Title XVI cases, New costs to the State of New York, and its counties could exceed $150 million. In addition, various State, local and private service programs that are supported by disability payments will have reduced capacities to provide needed services to the disabled population. Mental Health Programs will be particularly hard hit.

New York State's position has been and remains that any review of disability recipients should take every possible action to assure that an appropriate decision is made, that unnecessary injuries are avoided and that attention is given to providing adjustment assistance to those individuals who will no longer receive benefits.

To ACCOMPLISH THIS REQUIRES ACTION IN THREE MAJOR AREAS:

1. IMPROVEMENT IN THE OPERATING ACTIVITIES AND RELATIONSHIPS OF THE STATE OFFICE OF DISABILITY DETERMINATIONS (WE WILL BELOW DISCUSS SOME OF THE ACTIONS TAKEN IN THIS REGARD);

2. MODIFICATION IN BOTH SOCIAL SECURITY LAW AND PROGRAM ADMINISTRATION WHICH ADEQUATELY DEALS WITH THE UNIQUE PROBLEMS AND CIRCUMSTANCES OF THE ACDI POPULATION;

3. AND MOST CRITICALLY, A REVIEW AND REDEFINITION OF WHAT CONSTITUTES DISABILITY AND EMPLOYABILITY.

OFFICE OF DISABILITY DETERMINATIONS IMPROVEMENTS

WHILE CONGRESS AND THE SOCIAL SECURITY ADMINISTRATION HAVE PRIMARY RESPONSIBILITY FOR THESE ISSUES, NEW YORK HAS WORKED TO INSTITUTE MANY REFORMS THAT ARE POSSIBLE WITHIN FEDERALLY ESTABLISHED PARAMETERS. IN AN ATTEMPT TO ASSURE RATIONAL ADMINISTRATION AND PROTECTIONS FOR CLIENTS NEW YORK HAS IMPLEMENTED THE FOLLOWING MEASURES:

- INCREASED QUALITY CONTROL REVIEWS OF ALL TERMINATIONS HAVE BEEN INSTITUTED TO ASSURE THAT APPROPRIATE PROCEDURES HAVE BEEN FOLLOWED.
- FORMS AND PROCEDURES HAVE BEEN REVIEWED TO ASSURE THAT REQUESTS FOR INFORMATION PROVIDE CLEAR DATA FOR DECISION MAKING. IN ADDITION, SPECIAL ATTENTION HAS BEEN FOCUSED ON EFFORTS TO OBTAIN APPROPRIATE MEDICAL DATA FROM THE CLAIMANT'S TREATING PHYSICIANS.

- A REVIEW OF STAFF EXAMINER AND PHYSICIAN POSITIONS HAS BEEN UNDERTAKEN TO DETERMINE WHERE APPROPRIATE UPGRADING CAN OCCUR AND MONITORING OF PROVIDERS OF CONSULTATIVE EXAMINATIONS HAS BEEN EXPANDED.

- CONTACT HAS BEEN MADE WITH ALL TERMINATED CLIENTS TO INFORM THEM OF THEIR RIGHTS AND OF SERVICE AVAILABILITY AND A TELEPHONE HOTLINE TO PROVIDE ASSISTANCE TO CLAIMANTS HAS ALSO BEEN IMPROVED.

IN RECOGNITION OF THE PARTICULARLY HARSH IMPACT OF THE REDETERMINATION PROCESS ON PERSONS WITH PSYCHIATRIC DISABILITIES, NEW YORK HAS FOCUSED PARTICULAR ATTENTION ON THESE CASES IN THE FOLLOWING WAYS:

- THE STATE OFFICE OF DISABILITY DETERMINATIONS (ODD) HAS INFORMED SSA THAT IT WILL NOT CEASE BENEFITS TO A PSYCHIATRIC CASE FOR FAILURE TO COOPERATE WITHOUT A

DEFINITE STATEMENT FROM SSA THAT THE MANDATED CLIENT CONTACTS HAVE BEEN PERFORMED.

- PROCEDURES RELATING TO CLOSING OF PSYCHIATRIC CASES FOR FAILURE TO COOPERATE HAVE BEEN TIGHTENED.

- THE USE OF PSYCHIATRIC SOCIAL WORKER HOME VISITS HAS BEEN EXPANDED WHERE ADEQUATE MEDICAL DOCUMENTATION IS NOT AVAILABLE.

- THE DEPARTMENT HAS WORKED WITH MENTAL HEALTH AGENCIES WORKSHOPS AND TRAINING PROGRAMS TO ASSIST MENTAL HEALTH PROVIDERS IN UNDERSTANDING THE RULES OF THE DISABILITY PROGRAM. IN ADDITION, A MAJOR EFFORT HAS BEGUN TO LOCATE PRIVATE AGENCIES PROVIDING CARE FOR THE MENTALLY ILL TO DEVELOP DIRECT AND ONGOING INTERFACE.

MODIFICATION OF SOCIAL SECURITY LAW AND ADMINISTRATION

WHILE THE DISABILITY DETERMINATION PROGRAM WILL BE IMPROVED BY THESE STATE ACTIVITIES, ANY IMPROVEMENTS WILL BE MARGINAL AT BEST UNTIL BASIC PROGRAM REFORM OCCURS. SUCH REFORM MUST OCCUR AT THE NATIONAL LEVEL AND MUST ADDRESS THE CURRENT DEFINITION OF PERMANENT DISABILITY AS WELL AS THE DEFINITIONS, GUIDELINES AND DOCUMENTATION STANDARDS FOR DISABILITIES WHICH ARE PSYCHIATRIC IN NATURE.

AS THESE ISSUES ARE ADDRESSED, IMMEDIATE STEPS CAN BE TAKEN TO REMEDY THE MAJOR INEQUITIES OF THE CURRENT REDETERMINATION PROCESS. IN THIS REGARD, WE ASK FOR THE FOLLOWING REFORMS:

- THE CONTINUATION OF BENEFITS FOR NEEDY RECIPIENTS DURING THE APPEAL OF THEIR BENEFIT TERMINATION.

- EXTENSION OF THE PERIOD DURING WHICH CLAIMANTS WOULD RECEIVE BENEFITS AFTER TERMINATION TO SIX MONTHS.

- Federal funding of programs such as vocational rehabilitation, designed to assist former recipients to return to the labor market.

- Forgiveness of retroactive overpayments.

- Expansion of the representative/advocate concept to provide assistance to claimants throughout the process.

- Rationalization of case processing time standards.

- Procedures to assure that adequate data from all appropriate sources are obtained.

- Increased funding to allow expanded field contacts and other documentation efforts for psychiatric cases.

- o Expansion of reviews of terminated cases.
- o Extension of the time allowed for recipients to respond to due process notices.

It is gratifying that many of these proposals have been given serious consideration by Congress as well as by the Social Security Administration.

CHANGE IN DEFINITIONS

While the adoption of the above recommendations will improve circumstances for terminated clients, it is critical to recognize that they alone will not solve the severe problems primarily caused by the stringency of the definitions of disability and employability.

The Department of Social Services has initiated a study of claimants whose benefits have been terminated to identify their

CHARACTERISTICS AND NEEDS. THE PRELIMINARY RESULTS OF THIS STUDY SUPPORT OUR IMPRESSIONS REGARDING THE VULNERABLE NATURE OF THIS POPULATION. THE DATA SUGGEST THAT THE TYPICAL INDIVIDUAL LOSING BENEFITS IS A SINGLE MALE AGED FORTY ONE WITH NO OTHER SOURCE OF INCOME AND A LIMITED RESIDUAL FUNCTIONING CAPACITY. HE IS MOST LIKELY TO BE SUFFERING FROM A MENTAL ILLNESS, PARTICULARLY SCHIZOPHRENIA, OR FROM A MUSCULOSKELETAL DISORDER SUCH AS A BACK PROBLEM. THE QUESTIONABLE PROSPECTS FOR EMPLOYMENT FOR SUCH INDIVIDUALS IS SUPPORTED BY THE FINDING THAT NEARLY A QUARTER OF THOSE WHO HAVE LOST BENEFITS HAVE MADE A NEW APPLICATION FOR PUBLIC ASSISTANCE. THIS PERCENTAGE WILL GROW WITH TIME.

THE DEPARTMENT HAS ALSO UNDERTAKEN A REVIEW OF FEDERAL RULES, REGULATIONS AND PROCEDURES TO DETERMINE WHETHER THEY CONTRIBUTE TO DENIALS IN THE DECISION MAKING PROCESS. THE RESULTS OF THIS REVIEW WE BELIEVE CLEARLY ILLUSTRATES THE EXACTNESS AND STRINGENCY

OF THE PROCESS SPECIFIED AND THE SEVERE LIMITAIONS ON LATITUDE INVOLVED IN AMKING DISABILITH AND EMPLOYABILITY DECISION.

THE VULNERABILITY OF THE INDIVIDUALS INVOLVED AND THE STRINGENCY OF THE DISABILITY AND EMPLOYABILITY DEFINITIONS UTILIZED CLEARLY REQUIRES CONGRESS AND SSA TO RE-EXAMINE THE DEFINITIONS USED IN THIS PROGRAM. THIS IS PARTICULARLY TRUE WHEN IT SI RECOGNIZED THAT MANY OF THE CEASED CLIENTS WERE ORIGINALLY QUALIFIED FOR DISABILITY BENEFITS UNDER SETS OF RULES AND REGULATIONS AND DEFINITIONS WHICH WERE CONSIDERABLY LESS STRINGENT THAN TODAYS STANDARDS.

THE NEED FOR IMMEDIATE REFORM IN THE PERIODIC REVIEW PROGRAM CANNOT BE OVERSTATED. EXPANDED TO A NATIONWIDE BASIS, THIS PROGRAM COULD RESULT IN THE TERMINATION OF BENEFITS FOR WELL OVER ONE MILLION RECIPIENTS OVER THE NEXT THREE TO FOUR YEARS.

OUR STUDIES HAVE SHOWN THAT THE LARGE NUMBERS OF DISABILITY RECIPIENTS WHOSE BENEFITS ARE TERMINATED CANNOT REASONABLY EXPECT TO OBTAIN GAINFUL EMPLOYMENT AND WILL ULTIMATELY REQUIRE FINANCIAL ASSISTANCE FROM THE STATE.

FACED WITH GREATLY DIMINISHED RESOURCES, STATES WILL BE UNABLE TO MEET THESE PRESSING NEEDS AND THE NATION WILL BE FACED WITH A CRISIS OF MAJOR PROPORTION.

Senator **ARMSTRONG**. Thank you very much. That is a valuable insight, and we are glad to have it.

My colleagues, throughout the afternoon we have heard that the Administrative Law Judges have overruled a large proportion of the decisions made by the State agencies, and it is only fitting, I think, that our final witness is Judge Ainsworth Brown, who is vice president of the Association of Administrative Law Judges, who I presume has come here this afternoon to overrule a large proportion of the testimony which has been previously submitted.

Judge, you are good to come. You are a man of patience, and we are sorry to put you at the end of a busy afternoon; although perhaps you have found it interesting to hear how this thing looks from another perspective.

Judge **BROWN**. It certainly is.

Senator **ARMSTRONG**. May I ask that you hold your statement for just about 30 seconds, and then we will be ready to go?

Judge **BROWN**. Yes.

[Pause.]

Senator **ARMSTRONG**. Thank you, Judge. Please proceed.

STATEMENT OF JUDGE AINSWORTH BROWN, VICE PRESIDENT, ASSOCIATION OF ADMINISTRATIVE LAW JUDGES IN THE DEPARTMENT OF HEALTH AND HUMAN SERVICES, WASHINGTON, D.C.

Judge **BROWN**. I want to disabuse you right away, Mr. Chairman, that I would overrule anything. I know that's not my province. But I did hear many things, especially from your distinguished colleagues, earlier on in the afternoon that I was highly impressed with.

I would like to say that I would appreciate very much if the brief written statement that I had submitted to the committee could be included in the record of the hearing. I just have a few additional remarks—I know the time is late.

On behalf of the Association of Administrative Law Judges in the Department of Health and Human Services, we appreciate the opportunity come before you today. Our membership comprises a majority of the judges in the Department of Health and Human Services.

Judge Chester Shatz of Boston, Mass., sits to my right. He is director of region 1 of our association and is our legislative chairman.

At this critical juncture in the social security system, the integrity of the hearing process is being subjected to the greatest stress it has ever experienced. Not only are we confronted with a burgeoning onslaught of requests for hearings but starting with the consideration of the 1980 disability amendments we have also come under unwarranted criticism from within our employing agency. This criticism has continued from last summer to the recent past, when a high-ranking social security official testified before a Senate committee that the disability adjudicators were better able to evaluate medical evidence than administrative law judges—a proposition which would amaze most practicing lawyers as it would the framers of the Administrative Procedure Act, a statute which has protected litigant rights ever since the late 1940's.

The many complaints that members of both bodies of the Congress have received during the past year involving the continuing disability investigation program have become commonplace cases or a commonplace affair for most judges. We see these cases every day.

Since the protections given administrative law judges are personal in nature, it is incumbent upon us to insure that the hearing process remains a fair system which is professionally administered. This high responsibility on us brings with it tension from time to time with our employing agency. This is the nature of the fair hearing process.

As my written statement points out, Senate bill 2730 and 2731 will materially assist in maintaining the fairness in the adjudication of disability claims. We believe that the continuing interest in the fairness of the system by Congress will mean that the integrity of the process will continue.

I welcome any comments or questions that you have. I will let my statement be brief because of the lateness of the hour.

[The prepared statement of Judge Ainsworth Brown and answers to questions from Senator Heinz follow:]

Association of Administrative Law Judges in the Dept. of Health and Human Services

STATEMENT IN SUPPORT OF SENATE BILLS 2730 AND 2731 SUBMITTED BY AINSWORTH H. BROWN, VICE PRESIDENT, ASSOCIATION OF ADMINISTRATIVE LAW JUDGES IN THE DEPARTMENT OF HEALTH AND HUMAN SERVICES.

On behalf of the Association of Administrative Law Judges, I urge favorable consideration of these well conceived bills. They demonstrate a thoughtful and well-balanced approach to problems in the disability program observed within the last one or two years by the public, the Congress, and the Administrative Law Judges. These bills will preserve the right of Social Security claimants to receive a fair hearing before the Social Security Administration. Our Association has only a few suggestions for changes in S. 2731.

The Association urges support for S. 2730 which provides a temporary partial moratorium until January 1, 1983 on the accelerated continuing disability investigations. The moratorium will allow time for Judges and support staff who have been hired within the past year to become more efficient; it will allow time to reduce the heavy current pending workload; and it will allow time for those who manage the disability program to assess further the continuing disability program.

S. 2731 addresses several problems relating to the program of continuing disability investigations in a manner which will protect the interests of both the government and the public. Specifically, the requirement in Section 6 for Administrative Procedures Act (APA) rule making is one which the Association wholeheartedly endorses. One of the major causes of tension and conflict in the current management of the disability program is that different adjudicative standards are being used by the State Agencies and Administrative Law Judges. Several of the differences were described in the Bellman report which was furnished to the Congress earlier this year. Recently, the Social Security Administration has started to eliminate the differences through the issuance of Social Security Rulings. However, piecemeal elimination of differences in a solely in-house manner is not adequate. S. 2731 provides for the uniform standards that are essential to an efficient adjudication system. Equally important, the bill provides for public comment which is vitally important if there is to be judicial and public confidence in the fairness of the Social Security disability benefit program.

The Association of Administrative Law Judges also endorses the provisions of S. 2731 which mandate a face to face meeting at the reconsideration level between the State Agency decision maker and the individual whose benefits are to be terminated. We believe that many requests for hearings before Administrative Law Judges would be unnecessary if the adjudicator personally observed the disability applicant at reconsideration. However, the use of the term "evidentiary hearing" in Section 5 of S. 2731 to describe the face to face meeting at reconsideration causes us some concern. The term "hearing" connotes an Administrative Procedure Act proceeding. We, therefore, respectfully request that references to an "evidentiary hearing" be changed to "face-to-face interview." We also recommend that a State Agency Review Physician be required to participate in the interview process and to assist in the questioning of the claimant at reconsideration.

We note that in Section 8 relating to terminations, that under certain circumstances the case is referred to the Appeals Council. We believe that either in the language of the bill itself, or in the Committee report accompanying it, a statement should be made that the claimant is entitled to an APA hearing before an Administrative Law Judge.

Finally, we support the fact that S. 2731 will make medical improvement a statutory requirement in most instances. This will resolve a policy problem which has existed since about 1975. The current agency policy does not recognize medical improvement as a standard. The problem is briefly highlighted in the GAO report of March 3, 1981 at page 8. There are at least three distinct fact situations which have come under one policy umbrella for the last 6-7 years. These may be described as follows:

(a) Initial finding of disability correct, but medical improvement clearly shows claimant can now work

(b) Initial finding of disability clearly wrong or dubious

(c) Initial finding of disability correct as meeting a Listing or other existing criteria, but currently the Listing or criteria have been changed.

S. 2731 makes it clear that in situation (a) what policy should be applied and provides a different approach, at least by inference for (b) and (c). Having different policies for different situations as provided for in Section 8 will make the Agency explain to an individual who is said to be no longer disabled why he or she is no longer considered disabled in a more legally meanful manner.

Our Association appreciates the opportunity to share our views on these two bills and would be glad to provide any additional written information desired by the Committee. I will be glad to answer any questions you have.

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United States Senate
SPECIAL COMMITTEE ON AGING
WASHINGTON, D.C. 20510

August 20, 1982

Mr. Ainsworth Brown
Vice President
Association of Administrative Law Judges
in the Department of HHS
20 No. Pennsylvaina Avenue
Wilkes Barre, Pennsylvania 18701

Dear Mr. Brown:

I want to thank you for the excellent testimony you submitted on behalf of your association at the Senate Finance Committee's August 18 hearing on social security disability.

As I indicated during the hearing, the pressures of time precluded me from asking certain questions of you, which I am now submitting in writing for inclusion in the hearing record.

Question #1

Have the administrative law judges noticed any change in the quality of the State agency decisions denying disability benefits, especially in CDI cases, since the accelerated reviews were begun in March 1981?

Question #2

Do the administrative law judges concur in the finding of SSA's Office of Assessment that 97.5 percent of the CDI decisions terminating benefits are accurate?

Question #3

As indicated during the hearing, S. 2731 imposes on the Social Security Administration a medical improvement standard, while making allowances for improvements in medical technology. In your opinion, is such a standard desirable and appropriate for adjudicating CDI reviews? (You may refer to the attachment for the precise language under consideration.)

Quesiton #4

The Social Security Administration has testified that it will achieve uniform standards by including the P.O.M.S. in the Social Security Rulings. Are any of these standards such significant policy statements that they warrant public review and comment before they are made binding on administrative law judges? And, if so, why?

Question #5

You indicated at the hearing that this is a critical juncture, when the integrity of the hearing process is being subjected to increasing strain. What steps could Congress take to enhance the fairness and preserve the integrity of the hearing process?

Your prompt response to these questions would be greatly appreciated.

Sincerely,

John Heinz

JOHN HEINZ
Chairman

JH/fmh

Carolyn Weaver
Senate Finance Committee
2227 Dirksen SOB
Washington, D.C. 20510

Brian Waidmann
Senator Armstrong
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September 30, 1982

Senator John Heinz
United States Senate
Washington, D. C. 20510

Dear Senator Heinz:

On behalf of the Association of Administrative Law Judges in the Department of Health and Human Services, I want to thank you for your efforts in allowing me to testify on August 18, and to have the opportunity to respond to your incisive written questions. I regret that my docket has been such that I have been delayed in responding to your questions.

As a resident of Pennsylvania I am personally proud to be in a state who has a Senator who has the interest and understanding of the complexity of human services in general, and Social Security disability issues in particular. I hope that the answers I have developed on behalf of the professional association I serve will be of benefit to you in your effort to improve the Social Security Disability Program.

Again, thanks for the opportunity to comment.

Yours truly,

Ainsworth Brown

Ainsworth H. Brown
Vice-President
Association of Administrative
Law Judges

AHB/mjm

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RESPONSE TO QUESTION NO. 1

The changes in the quality of State Agency adjudication since March, 1981 are merely a continuation of the erosion of the process observed over the last several years. Beginning in the late 1970's, profound changes in disability policy were instituted. It is more accurate to describe the change in the policies the State Agencies were required to follow in evaluating the issue of disability as a divergence from regulatory language. Some changes in the State Agency determination policy may be related to processing time requirements. Others relate to the development of biases toward psychiatric impairments, particularly toward those claimants afflicted with alcohol dependency.

Often the State Agency determinations, especially in cessation cases, have been brief to the point of containing mere conclusions without supporting rationale. The evaluation of pain in the State Agency determinations is virtually nonexistent.

Judges with a number of years of experience can appreciate profound changes in quality which are not for the better.

RESPONSE TO QUESTION NO. 2

The answer to this question is an unqualified and emphatic "no." As recently as the President's September 28 news conference he pointed out that bureaucratic errors have been corrected following a hearing by an Administrative Law Judge. If the President determined that this was a matter worthy of comment it would seem that it is his perception that there is a problem with incorrect actions in the CDI process. The standards used to govern this assessment study must be ascertained and evaluated to understand the study itself. It is highly probable, if not certain, that the standards used came from the disability guidelines of the POMS. Our Association has gone on record before the Congress and within the Social Security Administration questioning the legality of the POMS criteria as valid substantive law, (See Serial 97-31 of the Subcommittee on Social Security of the Committee on Ways and Means, October 23, 28, 1981 testimony of the Association of Administrative Law Judges).

The "horror" cases which have been brought to the attention of Members of Congress constitute substantial evidence to contradict the assertion made by the Office of Assessment. The areas where a significant number of errors

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RESPONSE TO QUESTION NO. 2 Cont'd.

are made include psychiatric cases, pain cases, and cardiac cases. A bias is evident in the adjudication of cases involving mental and emotional illness, as pointed out in response to Question No. 1. While these claims are difficult to evaluate, in that they often do not lend themselves to adjudication according to totally objective procedures such as blood tests and x-rays, they, nevertheless, cannot be ignored or evaluated on the basis of simplistic standards like "the claimant could work if he stopped drinking."

Mr. Simmons' testimony on August 18 in responding to the issue of 97.5% accuracy versus the judges' allowance rate of more than 60% is partly valid in noting that new evidence is a way of explaining how different decisions can be correct at different levels in the same cases. This is in accordance with an explanation I gave Chairman Pickle of the Subcommittee on Social Security last October. However, there is another important reason for the disparity in results. The simple truth is that State Agencies are being required to follow narrower or more stringent criteria than ever before. These criteria have not been exposed to public scrutiny through rule making.

This raises the serious question as to whether the "new" criteria are really in accord with Congressional intent as to the meaning of disability as embodied in the statutory definition. Specifically, the questions concern:

a. May pain be a basis for considering a person disabled, and, if so, what standards are to be employed?

b. Is mental or emotional impairment to be evaluated in a very narrow and restrictive manner so that a person can only be disabled if he is in a strait jacket for 12 months or more or if he is so emotionally impaired as to be virtually paralyzed?

c. Can significant alcohol dependence which has not caused profound organic damage be considered to be a severe impairment under 20 CFR 404.1521?

d. Is a cardiac or cardiovascular impairment in which a person cannot adequately perform a treadmill stress test or performs it to 6 or 7 METS, be free of a disabling impairment?

e. Can a person with a bad back syndrome be disabled even though all of the requirements of listing 1.05 (c) are not satisfied?

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RESPONSE TO QUESTION NO. 3

The vast majority of CDI cases would be covered by a standard relating to medical improvement. Cases which might not be covered include situations where the claimant has returned to work, others where there was a mistake in the original grant of disability, and a relatively minor number involving a change in the medical listings. The change in medical technology issue is an insignificant consideration. Therefore, we would not question its inclusion.

There appears to be a trend developing in the courts requiring a standard of medical improvement. While this issue may be settled in the Supreme Court in a year or two, it would be more efficient for Congress to speak to the issue now so that Congressional intent will be clear and any qualifications can be expressly stated. There is no rational basis to reject a standard of medical improvement. If "disability" can be measured or determined, a material change from this status can also be measured or determined. Only where the original determination is dubious or questionable, is there a problem in determining improvement. Even progress in medicine can be demonstrated and could well constitute medical improvement.

It is difficult to understand the reluctance of disability policy makers to accept the concept of medical improvement in the context set forth. Fundamental fairness to claimants would not be an insignificant consideration. With the publication of the qualifications as set forth above, claimants and their representatives would know more precisely that the grant of disability is not a lifelong proposition unless the impairment or impairments are definitely permanent. Where a cessation takes place then a claimant is put on adequate notice as to why disability is said to have ceased. It is this aspect of due process which a disability applicant has a reasonable right to be afforded by his government. It is not too much to expect a modest amount of fairness. This is also good public policy because it will contribute to public confidence in the disability program.

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RESPONSE TO QUESTION NO. 4

The stated position of our Association is that all standards of adjudication bearing on the issue of disability ought to be subject to public review and comment as provided for in S. 2731. However, since practical legislative considerations dictate some form of compromise, we strongly urge that certain key standards be exposed to the rule making procedures of the Administrative Procedure Act.

These are:

1. Any and all standards relating to the determination of residual functional capacity (RFC).
2. Definition of a non-severe impairment (i.e., the so called "negative"listings).
3. RFC for musculoskeletal and cardiovascular and mental impairment.
4. Sequential evaluation process
5. Loss of speech
6. Mental deficiency - supplemental criteria
7. Medical equivalence
8. Evaluation of mental disorders
9. Duration of impairment
10. Capability to do other work - both exertional and non-exertional impairments

RESPONSE TO QUESTION NO. 5

The first step which I would respectfully suggest that the Congress could take would be to send a clear and unambiguous message to the leadership of the Department of Health and Human Sciences and the Social Security Administration that it is the firm intent of Congress that the fairness of the Social Security hearing process be maintained. This could be accomplished by a resolution indicating that the independence of the hearing process is an important concern

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RESPONSE TO QUESTION NO. 5 Cont'd.

of Congress; that substantial and important procedural rules should be subject to rule making and not exempted from the protections of the Administrative Procedures Act; and that more emphasis should be placed on the initial phases of adjudication to insure that full development and consideration is to be carried out by the State Agencies.

To preserve the independent status of the hearing process, there are two legislative proposals which are being developed. The first relates to the creation of a Corps of Administrative Law Judges. This proposal is being developed by the Conference of Administrative Law Judges of the American Bar Association and will be considered by the Association at its mid-winter meeting. This concept will provide for efficiency and eliminate agency interference which currently is possible through control of housekeeping functions.

The second proposal relates to a reconfiguration of the Office of Hearings and Appeals of the Social Security Administration into a review commission concept. This will take the hearing activity out of the Social Security Administration and the Department of Health and Human Services. This is vitally important in order to maintain the necessary independence which gives the public confidence in the hearing process. With commentary in the media as to waivering confidence in the Social Security System, this proposal will be a positive factor in fostering renewed confidence in the system.

Over the past several years, the intrusions into the hearing process by the insatiable desire to increase "production" and now the on-going criticisms of the Judges and puffing as to the accuracy of the reconsideration determinations are ominous portents for the continued integrity of the hearing process. The "Mary Poppins" statistical game that the CDI's are "practically perfect" is more than credulity can bear. Constituent complaints to Congress by those caught up in the review process in conjunction with a persistent allowance rate at the hearing level of nearly 2 out of 3 cases cannot be fully rationalized on the basis of "new evidence." Unless the Congress speaks in an affirmative fashion, the hearing process may suffer irreparable damage.

I believe special attention should be given to the incisive statement submitted for the August 18 hearing by Eileen P. Sweeney on behalf of the National Senior Citizens Law Center. She points out some of the lawless aspects of disability adjudication policy over the last several years and the perfidious implications of the volume providers of

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RESPONSE TO QUESTION NO. 5 Cont'd.

of consultative examinations. The whole issue of the selection and use of consultative examiners should be given much closer scrutiny. The money spent for these examinations is, at times, not a prudent use of trust fund moneys. For example, in Pennsylvania the fee of $35 has remained unchanged for years until the very recent past. It's effect was to drive away competent physicians or to discourage them from rendering thorough examinations and legally competent reports.

In a conversation with a State Agency adjudicator within the past years, the subject of a survey of disability adjudicators arose. I was advised that the only way such a questionnaire could be candidly answered would be if it were sent to the home address of the individual adjudicator. In view of the allegations of significant errors made by Administrative Law Judges in contrast to a high degree of accuracy by State Agencies, an objective and carefully crafted questionnaire could elicit significant information if the study were done in a manner designed to protect adjudicators from reprisal and intimidation. Great care would need to be exercised in the language of the survey questions in order to eliminate bias which has been observed in some past questionnaires directed to Administrative Law Judges. Currently, another survey is underway by a political science professor who has become interested in the Social Security hearing process. Congress might receive some valuable insight into the disability adjudication system which has been the subject of so much recent controversy through an objective survey.

Finally, I reiterate for emphasis, if Congress wishes to renew its commitment to a fair, independent, and professionally constituted hearing process for Social Security adjudication, a firm pronouncement is needed now to impress congressional intent on the policy makers in the Social Security Administration. Without such an expression, the mounting pressures may be so great as to alter the nature of the hearing system into an agency controlled program. If I am correct that Congress would not want to allow the development of a process which would be no more than a cynical facade of a due process system--now is the time to speak before the damage becomes irreparable.

Senator ARMSTRONG. Judge, we are grateful to you. We will incorporate your statement in full in the record.

Members of the committee, your questions or observations?

Senator HEINZ. Judge Brown, I heard you endorse S. 2730 and S. 2731. S. 2730 is a temporary, partial CDI moratorium. S. 2731 is intended to be a comprehensive reform of the system. Do you feel both bills represent good policy?

Judge BROWN. Yes. I only have a few suggestions to make: one in particular, with the face-to-face interview, I feel if you have the State agency review physician present that will add a lot more to the process, because I think the expert eye of a physician at that process will identify some things that laymen might not ordinarily be aware of.

The other point that I made, and it is merely a matter of language, is to change the wording to "a face-to-face interview," rather than have some confusion in the record about calling the face-to-face proceeding a "hearing." Hearing is a rather special term that we are interested in, and I think, to save some confusion, it would be better if the Congress could see its way clear to change that language.

Senator HEINZ. One last question: It is my understanding that 45 percent of these redeterminations that are made involve a redetermination of mental impairment. Is that correct?

Judge BROWN. I wouldn't say that that has been my personal experience. We have seen psychiatric disablities come up frequently, but whether it is 45 percent, I really can't speak to that.

Senator HEINZ. Is it more like 30 to 35 percent?

Judge BROWN. Yes. They play a prominent part in the continuing review cases.

Senator HEINZ. It is my understanding that State disability determination agencies have very, very few trained psychiatrists to evaluate mental inpairments. Is that your experience?

Judge BROWN. Well, I guess my answer would be on the basis of my own empirical experience in adjudicating cases in Pennsylvania. I think that the circumstantial evidence from my personal point of view would suggest that. I know in my own hearings I resort to the use of medical advisers, board-certified experts, to help me evaluate this very, very difficult area. This is probably the most difficult area in adjudication to evaluate, by its very nature. So I try to compensate for that in my own experience by trying to go to an expert.

Senator HEINZ. Mr. Chairman, I just want to thank Judge Brown. Although he is here representing, as is very clear, a national association, I am also proud to claim him as a resident of Pennsylvania.

Thank you, Mr. Chairman.

Senator ARMSTRONG. Thank you, Senator Heinz.

Senator Durenberger?

Senator DURENBERGER. One question, Mr. Chairman.

What is your particular view on the job impairment issues? I raised them earlier, and Bill Cohen spoke to them.

Judge BROWN. I can't give you a position of our association; I can just give you a personal comment, for whatever that is worth.

Senator DURENBERGER. I would appreciate it.

Judge **Brown**. I would say that to discuss it in general terms is maybe misleading. I think that, when you get down to cases, so to speak, if you carefully evaluate the vocational factors I think the national economy test which has been discussed this afternoon is not that much of an impediment or detriment to a claimant being successful in pursuing a disability claim.

I think what is more important, if you carefully evaluate the residual functional capacity and then, in our case when you have a vocational expert at the hearing, place before the vocational expert all of the limitations which are reasonable to take from the medical evidence, then I think that aspect of the test of disability is not quite as important as other facets—that is, evaluating what the impairment is and what limitations it causes.

But I do think that you have to go into great detail in the vocational question, otherwise you can have some of the problems that have been discussed this afternoon.

Senator **Armstrong**. Judge, do you handle a lot of these cases in the course of a year?

Judge **Brown**. Oh, 400 to 500.

Senator **Armstrong**. Do you get much correspondence about it from Members of Congress?

Judge **Brown**. I think I understand where you are going. I guess I do.

Senator **Armstrong**. How many times a year would you hear from a Member of Congress?

Judge **Brown**. It is more from House Members than from Senators.

Senator **Armstrong**. We have a saying in the Senate which is "Write your Congressman." [Laughter.]

Judge **Brown**. Well, I just think that people are more familiar with their local Congressman. They know that they have two Senators from their State, and they tend to go to a name that they are a little bit more familiar with in their own bailiwick. In the vast majority of the cases I get a letter from the local Congressman, probably.

Senator **Armstrong**. In a majority of the 400 to 500 cases that come before you you have a letter from a Congressman?

Judge **Brown**. I would say so, particularly in the area where we get most of our work.

Senator **Armstrong**. What do these letters say?

Judge **Brown**. They ask my attention to the case. There is one Congressman who at times takes a lot of interest in his constituents' cases, to the extent that he will give me a little argument on behalf of his constituents; he will associate medical evidence to support his argument. The interesting thing is—and maybe this is because he is a lawyer—I find that his arguments are sometimes very well taken. But that is on the basis of the merits of what he has to say to me, not because of any influence.

I can state categorically that since I have been an administrative law judge no Congressman or Senator has ever tried to influence me in any way, shape, or form, other than as to the status of a case, to ask my careful consideration of a case, and give me medical evidence which he thinks I don't have. I have never had any pressure in any way, shape, or form from anybody in Congress.

So this is one judge's experience which I would assume is probably shared by the vast majority. I think there may be some feeling by constituents that because their case is looked upon with favor by an administrative law judge, and they had contacted a Congressman, they may put 2 and 2 together and come up with 5; but that is the only explanation I can give to you for the issue that was raised earlier.

Senator **Armstrong**. I am not sure I understand your observation. Is your point that someone might put 2 and 2 together and get 5——

Judge **Brown**. Because they wrote to a Congressman, and because they got a favorable administrative law judge decision, they might think having gotten in touch with the Congressman or the Senator had something to do with how one of us decided the case.

Senator **Armstrong**. But in fact it wouldn't have had anything to do with it?

Judge **Brown**. I have never even heard that in discussing work with colleagues.

Senator **Armstrong**. Is there anything else for the good of the order?

I'm not sure how far to go with that line of questioning. I think that is as far as I want to go today, but I am intrigued by it—not because I know much about it but just because I hear whispers that at least in some instances the influence of Members of Congress is substantially greater than you have portrayed it today.

Maybe I will carry it just one half-step further to ask this question: I am not an attorney, by the way. If I were to write, as a Member of the Congress or the Senate, a Federal district judge, urging him to take a particular decision, presenting say medical evidence in a case that was pending before him, what would he do with that letter?

Judge **Brown**. I am not sure I can speak to that. I don't know whether that is done in practice. All I can tell you is what my experience is and what the experience of my colleagues is.

I suspect that because we are housed in the executive department, and we are not separated as the judiciary is, that there is more inclination to communicate with us than with our colleagues in the article III judiciary. But that is just speculation on the spur of the moment.

Senator **Armstrong**. Let me just ask you: Is there any legal counsel in the room? I mean, is there a lawyer in the room. That is what I mean.

[No response.]

Senator **Armstrong**. Do you mean this whole hearing is going forward, and there isn't a lawyer here?

Senator **Heinz**. You are beginning to talk like a lawyer.

Senator **Armstrong**. Well, I think I will seek some further advice from counsel.

The point I am really driving at is whether or not there ought to be some standard of consideration. I have an instinct that the administrative law process, falling as it does between discretionary executive branch kinds of actions and completely judicial functioning, are subject at least to the suspicion of abuse—as you say, 2 and 2 equals 5—and maybe as we consider legislation aimed at solving the problems that we have discussed this afternoon that we may want to make some decision or set some standard for congressional participation in the process. Or we might just say that ALJ's ought to pay no attention whatsoever to such inquiries, or they ought to throw them away, or that their staff ought to open them and file them without the judge seeing them. I don't know.

Judge **Brown**. If I could make one comment it would be that I think that constituent contact with House Members and Senators provides you with the kind of insight that I think you have into the continuing disability investigation program. And if you would limit the contact between the Congress and the administrative law judge you might not necessarily always get a full readout, so to speak, on what is happening; because I know that at various times I have sent more specialized responses, particularly to Congressmen, when I felt that there was something that they really needed to know about the process in a given case. So I don't think I would want to cut off the contact with us, because I would like to think that it provides you folks with useful information.

Senator **Armstrong**. Would you feel the same way about a Federal district judge? Or, say, a judge of a circuit court?

Judge **Brown**. I think there may be some distinctions there.

Senator **Armstrong**. Unless there is something further, I am grateful to all the witnesses.

Judge **Brown**. I just want to say one thing, please. For what my information basis is worth, I don't believe that this is a problem.

Senator **Armstrong**. On that reassuring note, this hearing is adjourned.

Thank you, Judge.

[Whereupon, at 5:29 p.m., the hearing was concluded.]

[By direction of the chairman the following communications were made a part of the hearing record:]

STATEMENT OF SENATOR JIM SASSER

Mr. Chairman, I would first of all like to thank you and Members of the Senate Finance Committee for allowing me to present this written testimony today.

As you sit here today, the social security disability program is itself severely disabled and in need of major repair. Both the variety and number of legislative approaches which have been offered to deal with the problem attest to its seriousness and the urgency with which it must be dealt. It is my sincere hope that Members of this committee will act quickly to remedy the current injustices in the disability program.

I became acutely aware of this problem in January of this year. In addition to letters from constituents recounting numerous incidents of erroneous terminations from the disability rolls, I received allegations of the existence of a quota system that was being used to systematically reduce the disability rolls. In March I brought this problem to the attention of the Secretary of the Department of Health and Human Services, Mr. Schweiker. In April I instructed the General Accounting Office to conduct an investigation of the Memphis Social Security Administration District office to determine whether quotas were being used to terminate the benefits of Disability Insurance recipients.

The final GAO report was released in June and proved inconclusive with respect to these allegations. However, it did reveal criticisms of the disability determination system which parralled those heard in other states. The report concluded that the problems in Tennessee are not unlike those found in Ohio, New York, Pennsylvania, and California, suggesting that deficiencies in the Continuing Disability

Investigations (CDI's) process are widespread and not the result of isolated instances or unique to any geographical region of the country.

The criticisms included: complaints directed at the quality of consultative examinations being performed at the request of the State disability determination system; complaints that the consultative examinations were too short, were not comprehensive, and did not adequately cover the claimants' impairments, and complaints that some consultative physicians are rude, prejudiced, and unprofessional. The employees also believed the Tennessee disability determination system (DDS) is experiencing organizational and workload problems because of the current continuing disability investigation (CDI) program. They also revealed there was a high case backlog and some pressure to reduce it.

It is little wonder that the social security disability program is currently experiencing such a deluge of complaints which has prompted the close scrutiny of several Members of Congress.

In 1980, the Congress adopted the Disability Amendments in response to the dramatic growth of the program during the early and mid 70's. A major provision of these amendments required the Social Security Administration, beginning in January 1982, to review the cases of disabled workers on the disability rolls at least once every three years, except where the disability was considered to be permanent.

However, in March 1981, the Reagan Administration, in an attempt to realize savings, decided to accelerate these reviews some nine months ahead of the January 1982 implementation date. This was done despite the lack of appropriate resources with which to handle the large increases in State agency caseloads. To a great extent this has contributed to the inequitable treatment and erroneous termination of a substantial percentage of the disabled population.

In Tennessee alone, the disability determination system in Nashville is scheduled to review approximately 11,179 cases. Next year this caseload will increase to 19,747, and in 1984 there are 30,896 cases scheduled for review.

Now, the original purpose of the 1980 disability amendments was to weed out those individuals who were no longer eligible for disability benefits. I strongly support any and all efforts to rid Government programs of waste, fraud, and abuse. In many cases there may be sufficient justification and cause for removing individuals from the disability rolls. If they do not belong on the rolls, then they should be removed.

However, it is apparent that the rights of disability beneficiaries are being callously disregarded and abused through the hasty and inefficient administration of unfair and unjust policies. In far too many cases, what we are seeing is that truly deserving beneficiaries are being systematically knocked off the rolls in an effort to reduce costs. Substantial evidence indicates that gross inequities are occurring not only in Tennessee, but across the Nation. Many beneficiaries are being indiscriminately terminated without so much as the benefit of a medical examination.

The legislation I have introduced would provide for a face-to-face evidentiary hearing at the reconsideration level of appeal in the hope that personal contact will reduce the high percentage of erroneous terminations at this level. Under my bill the disabled beneficiary would continue to receive benefits until this time and should it be necessary to carry the appeal to the Administrative Law Judge level, the individual would continue to be eligible for medicare benefits.

The importance of protecting disability beneficiaries from erroneous terminations cannot be understated. Examples where desperation and despair follow termination of these benefits are plentiful. A recent article in the Memphis Commercial Appeal detailed several cases where adverse impacts upon disability recipients were felt. In one case, an East Tennessee lawyer told of one of his clients--a man who suffered from paranoid schizophrenia--who committed suicide because his benefits were terminated. The lawyer said the man left a note saying that was the reason he took his life.

Another woman, 51 years of age, suffers from multiple sclerosis, lupus, two ulcers, cystitis, a tumor, and a deteriorating spine, yet her benefits were terminated last October.

Two weeks ago I received a letter from an Attorney's office in Oak Ridge, Tennessee. In the letter the attorney, Ms. Dorothy Stulberg, outlined ten specific cases in which disability benefits were terminated. These cases are merely illustrative of what is happening across the country. Ms. Stulberg writes that "there is almost no way to express in words the hardship and the pain needlessly caused by the actions of the Social Security Administration"with respect to disability terminations.

CASE NO. 1-Male, 48 years of age, this man is on nine kinds of medicine. He has had two heart attacks while on social security disability. He has urinary problems, bleeding bowel, stomach problems, headaches, ankles swell, bad nerves, chest pains, and back pains. He became so desperate because of no income

CASE NO. 1(continued) that he tried to work and broke his arm.

CASE NO. 2-female, 34 years of age, this woman suffers from arthritis, headaches, seizures, psychological problems, frequent kidney infections, constant pain from a serious automobile accident. This lady is so upset about being terminated that she has overdosed. All doctors statements indicate that she is unable to work. She has absolutely no funds.

CASE NO. 3-female, age 57, this woman worked for thirty years and was forced to take a medical discharge because of her physical condition. She voluntarily tried to return to work but was unable to do so. She also suffers from lupus, one leg is shorter than the other, must use a walker for support, has stiff fingers, suffers from hallucinations, sleep paralysis, on many medications ahd has organic brain disease. After contributing to social security for thirty years and being unable to work, she is now being denied social security disability benefits.

CASE NO. 4-male, age 46, this man looks 65. He was terminated from disability and for one solid year he and his family had no income at all. Benefits were resumed in March 1982 without even a hearing. The midicals were so extreme that the Administrative Law Judge determined that it was necessary to have a hearing. It was so obvious that this man had psychological and physical problems. During the entire year he was not able to get the medication that was necessary to treat his illnesses. Our office borrowed and begged money from local churches in order that his family could survive.

CASE NO. 5-male, 44 years old, this man suffers from bronchial emphysema, a bad back, and eye trouble. He has been without any funds at all for about seven months. He needs medication in order to ease his breathing problems. He has no funds to purchase medication. He has called our office begging for us to help him find some money so he can at least breathe. He has children. He has gone to the local health department and they have told him that they have money only for his high blood pressure which was extremely high. He weighs only 138 pounds and is 6 feet 3 inches tall.

Mr. Chairman, I could go on and on with examples of needless hardship. I think that these five examples, however, more than make the point. The issue is crystal clear and we must implement corrective legislation quickly to stem these gross injustices which are occurring every day.

On June 22, I introduced S. 2659 to address these inequities. The major provisions of my bill are as follows:

- the bill provides for an adjustment period not to exceed six months wherein disability benefits will be continued until the reconsideration hearing
- the bill provides that a face-to-face evidentiary hearing be conducted at the reconsideration hearing.
- the bill allows for the extension of medicare eligibility until such time as a decision is reached by an Administrative Law Judge.
- the bill requires the Secretary of Health and Human Services to report to the Congress on a quarterly basis information which will better facilitate an accurate evaluation of the actual continuing disability investigations process.

The difference between this bill and other proposals primarily lies in the length of time wherein payment of benefits are paid. The legislation I have offered provides that benefits be paid until the reconsideration hearing as opposed to paying the benefits until the Administrative Law Judge hearing.

I believe that this approach is preferrable from the standpoint of cost-effectiveness. According to the Congressional Budget Office, payment of benefits through the Administrative Law Judge level will cost approximately $120 million in 1983, $80 million in 1984, and $85 million in 1985. These figures include repayment of overpayments. In comparison, payment of benefits through reconsideration including a face-to-face hearing at the reconsideration level will cost $40 million in 1983, $45 million in 1984, and $30 million in 1985. Thus, my bill would save approximately $170 million over the next three years. Furthermore, according to Social Security Administration actuaries, only about 50 percent of these overpayments are recoverable.

In order to compensate for those individuals who are erroneously terminated, my bill provides for the extension of medicare eligibility until the ALJ hearing. In most cases, eligibility for medicare is just as if not more important than the disability benefits themselves. According to the Congressional Budget Office, this provision would cost approximately $45 million in 1983, $50 million in 1984, and $55 million in 1985. This provision is important because it is extremely difficult for individuals who have been on the disability rolls to procure hospitalization insurance once they have been terminated from the disability rolls. Insurance carriers are reluctant to carry these individuals and even if they do the insurance premiums are very high.

As I have already mentioned, providing for a face-to-face hearing at the reconsideration hearing will hopefully reduce the inexcusably high percentage of erroneous terminations at this level. The individual facing termination of disability benefits should be afforded an opportunity to face those deciding the appeal as well as produce evidence which might have a bearing on the outcome of the appeal at the earliest possible time.

Finally, it is currently very difficult to accurately gauge the exact depth and scope of the problem simply because no individual or agency is charged with collecting data relevant to the number of continuing disability reviews, the number of initial benefit termination decisions resulting from these reviews, the number of such termination decisions with respect to which reconsideratin is requested or a hearing is requested or both, and the number of such termination decisions which are overturned at the reconsideration or hearing level.

Under my bill, the Secretary of the Department of Health and Human Services would be responsible for reporting this specific information to Congress on a quarterly basis. These reports will enable both Congress and the Secretary to better measure the disability review process and make changes as they are necessary.

It is my sincere hope that this committee will carefully consider the legislation I have offered here today and will move quickly to adopt what is intended to be a temporary solution to a most crucial problem. While a comprehensive disability package is needed, I do not believe such a comprehensive package could be adopted before the end of this year. It is therefore incumbent upon us to address this problem in an effective and expeditious manner.

Once again, I would like to express my thanks and appreciation to the Chairman and the Members of this committee for allowing me to offer this testimony today.

II

97TH CONGRESS
2D SESSION

S. 2659

To amend the Social Security Act to provide that disability benefits may not be terminated prior to completion of the reconsideration process including an evidentiary hearing, to provide that medicare entitlement shall continue through the administrative appeal process, and to require the Secretary of Health and Human Services to make quarterly reports with respect to the results of periodic reviews of disability determinations.

IN THE SENATE OF THE UNITED STATES

JUNE 22 (legislative day, JUNE 8), 1982

Mr. SASSER introduced the following bill; which was read twice and referred to the Committee on Finance

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A BILL

To amend the Social Security Act to provide that disability benefits may not be terminated prior to completion of the reconsideration process including an evidentiary hearing, to provide that medicare entitlement shall continue through the administrative appeal process, and to require the Secretary of Health and Human Services to make quarterly reports with respect to the results of periodic reviews of disability determinations.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

11-346 O—82——22

PAYMENT OF ADJUSTMENT DISABILITY BENEFITS DURING RECONSIDERATION

SECTION 1. (a) Section 223 of the Social Security Act is amended by adding at the end thereof the following new subsection:

"Payment of Adjustment Benefits During Reconsideration

"(g)(1) In any case where—

"(A) an individual is a recipient of disability insurance benefits, or of child's, widow's, or widower's insurance benefits based on disability,

"(B) the physical or mental impairment on the basis of which such benefits are payable is found to have ceased, not to have existed, or to be no longer disabling, and as a consequence such individual is determined not to be entitled to such benefits, and

"(C) a timely request for reconsideration of the determination that he is not so entitled is made under section 221(d)(l),

entitlement to and payment of such benefits and any other benefits based on such individual's wages and self-employment income shall not be terminated until such reconsideration under section 221(d) has been completed and the finding under subparagraph (B) of this paragraph has been upheld on such reconsideration, or, if earlier, until the end of the sixth month after the month in which such initial termination determination was made.

"(2) Paragraph (1) shall not apply in the case of a termination of benefits which is based upon a finding made in accordance with subsection (d)(4) that services performed by the individual or earnings derived from services performed by the individual demonstrate such individual's ability to engage in substantial gainful activity.".

(b) The amendment made by subsection (a) shall apply to determinations (that individuals are not entitled to benefits) made after the date of the enactment of this Act.

RECONSIDERATION PROCEDURE FOR DISABILITY BENEFITS

SEC. 2. (a) Section 221 of the Social Security Act is amended by redesignating subsections (d) through (i) as subsections (e) through (j), respectively, and by inserting after subsection (c) the following new subsection:

"(d)(1) Any initial decision the Secretary renders with respect to an individual's rights for a payment under this title (including a decision the Secretary renders by reason of a review under subsection (c)) in the course of which a determination relating to disability or to a period of disability is required for such payment and which is in whole or in part unfavorable to such individual shall contain a statement of the case, in understandable language, setting forth a discussion of the evidence, the Secretary's decision, and the reason or reasons upon which the decision is based. Upon request by any such individual, or by a wife, divorced wife, widow, surviving divorced wife, surviving divorced mother, husband, widower, child, or parent, who makes a showing in writing that his or her rights may be prejudiced by such a decision, he or she shall be entitled to reconsideration of such decision under this subsection. Any such request with respect to any such decision must be filed within 60 days after notice of the decision is received by the individual making such request, or within such longer time as the Secretary may provide in any case where good cause is shown as to why filing was delayed beyond such 60 days.

"(2)(A) If a reconsideration is requested by an individual under paragraph (1) and a showing is made by such individual that he or she may be prejudiced in such decision by a determination relating to disability or to a period of disability, such individual shall be entitled in the course of such reconsideration to a determination relating to such disability or period of disability.

"(B)(i) In the case of a reconsideration to be made by the Secretary of a decision to terminate benefits in which a determination relating to disability or to a period of disability was made by a State agency, any determination under subparagraph (A) relating to disability or to a period of disability shall be made by the State agency, notwithstanding any other provision of law, in any State that notifies the Secretary in writing that it wishes to make determinations under this subparagraph commencing with such month as the Secretary and the State agree upon, but only if (I) the Secretary has not found, under subsection (b)(1), that the State agency has substantially failed to make determinations under this subparagraph in accordance with the applicable provisions of this section or rules issued thereunder, and (II) the State has not notified the Secretary, under subsection (b)(2), that it does not wish to make determinations under this subparagraph. If the Secretary once makes the finding described in clause (I) of the preceding sentence, or the State gives the notice referred to in clause (II) of such sentence, the Secretary may thereafter determine whether (and, if so, beginning with which month and under what conditions) the State may again make determinations under this subparagraph.

"(ii) Any determination made by a State agency under clause (i) shall be made in the manner prescribed for determinations under subsection (a)(2) and regulations prescribed thereunder, except that it shall be made after opportunity for an evidentiary hearing at which the individual requesting the reconsideration and the individual (if different) whose disability or period of disability is in question shall have a right to appear.

"(3) A decision by the Secretary on reconsideration under this subsection in the course of which a determination relating to disability or to a period of disability is required and which is in whole or in part unfavorable to the individual requesting the reconsideration shall contain a statement of the case, in understandable language, setting forth a discussion of the evidence, the Secretary's decision, and the reason or reasons upon which the decision is based.

"(4) The Secretary shall prescribe by regulation procedures for the reconsideration under this subsection of issues other than issues relating to disability or a period of disability.".

(b) Section 221 of such Act is further amended—

(1) in subsection (b)(1), by inserting "under subsection (a)(1) or subsection (d)" after "disability determinations" the first place it appears, and by inserting before the period the following: "or the disability determinations referred to in subsection (d)(2) (as the case may be)";

(2) in subsection (b)(2), by inserting "or under subsection (d)(2) (as the case may be)" after "subsection (a)(1)" the first place it appears, and by inserting before the period in the last sentence the following: "or the disability redeterminations referred to in subsection (d)(2) (as the case may be)";

(3) in subsection (b)(3)(A), by inserting "under subsection (a) or subsection (d)" after "function", and by inserting "under subsection (a) or subsection (d) (as the case may be)" after "process";

(4) in subsection (b)(3)(B), by inserting "under subsection (a) or subsection (d)" after "function", and by inserting "under subsection (a) or subsection (d) (as the case may be)" after "process";

(5) in subsection (e) (as so redesignated by subsection (a) of this section), by striking out "(c), or (g)" and inserting in lieu thereof "(c), (d), or (h)";

(6) in subsection (f) (as redesignated by subsection (a)), by striking out "under this section" and inserting in lieu thereof "or subsection (d)(2)", by inserting "or under subsection (d)(2), as the case may be" after "under subsection (a)(1)" the second place it appears, and by striking out "subsection (f)" and inserting in lieu thereof "subsection (g)";

(7) in subsection (h) (as redesignated by subsection (a)), by inserting "or subsection (d)(2)" after "subsection (a)(1)", by inserting "under subsection (a)(1) or subsection (d)(2)" after "disability determinations" the second place it appears, by inserting after "guidelines," the following: "in the case of disability determinations under subsection (d)(2) to which subparagraph (B)

thereof does not apply,", by inserting "under subsection (a) or subsection (d)" after "disability determinations" the third place it appears, by inserting "or the determinations referred to in subsection (d) (as the case may be)" after "in subsection (a)", and by adding at the end thereof the following new sentence: "In the case of a reconsideration by the Secretary of a decision to terminate benefits, any disability determination made by the Secretary under this subsection in the course of such reconsideration shall be made after opportunity for an evidentiary hearing at which the individual requesting the reconsideration and the individual (if different) whose disability or period of disability is in question shall have a right to appear."; and

(8) in subsection (i) (as redesignated by subsection (a)), by adding at the end thereof the following new sentence: "An individual who makes a showing in writing that his or her rights may be prejudiced by a determination under this subsection with respect to continuing eligibility shall be entitled to a reconsideration and a hearing to the same extent and in the same manner as provided under subsections (d) and (e).".

(c) The amendments made by this section shall apply with respect to requests for reconsideration of decisions by the Secretary of Health and Human Services filed after the date of the enactment of this Act.

CONTINUATION OF MEDICARE ENTITLEMENT DURING ADMINISTRATIVE APPEALS PROCESS

SEC. 3. Section 226(b) of the Social Security Act is amended by striking out "the month in which notice of termination of such entitlement to benefits or status as a qualified railroad retirement beneficiary described in paragraph (2) is mailed to him" and inserting in lieu thereof "the month in which such individual's entitlement to benefits or status as a qualified railroad retirement beneficiary described in paragraph (2) has been terminated and such individual has exhausted all possible administrative remedies (or such individual has failed to request such remedies within the time period provided for such requests) for challenging such termination, up to and including a decision rendered by the Secretary after a hearing as provided in section 221(e) or a final decision rendered by the Railroad Retirement Board".

REPORT ON PERIODIC REVIEW OF DISABILITY DETERMINATIONS

SEC. 4. Section 221(i) of the Social Security Act is amended by inserting "(1)" after "(i)" and by adding at the end thereof the following new paragraph:

"(2) The Secretary shall transmit to the Congress on a quarterly basis a report setting forth the number of continuing eligibility reviews carried out under paragraph (1), the number of initial benefit termination decisions resulting from such reviews, the number of such termination decisions with respect to which reconsideration is requested under subsection (d) or a hearing is requested under subsection (e), or both, and the number of such termination decisions which are overturned at the reconsideration or hearing level.".

STATEMENT

of the

AMERICAN ASSOCIATION OF RETIRED PERSONS

on the

SOCIAL SECURITY DISABILITY INSURANCE PROGRAM

before the

COMMITTEE ON FINANCE

UNITED STATES SENATE

AUGUST 18, 1982

The American Association of Retired Persons appreciate the opportunity to comment on current problems with the administration of the Social Security Disability Program. Recent administration of the continuing disability investigation (CDI) process has proved to be poorly managed as evidenced by the numerous accounts of human suffering and hardships of disability recipients - many of whom are older Americans.

In January of 1982, 62.5% of the total disability recipient population was between the ages of 50 and 64 years, 7.4% were persons aged 62 through 64. The disabled elderly rely most heavily on the Social Security disability insurance program and have a great deal at stake with the current review procedures and future changes in the program. Disability insurance is important to them, because for the older worker who becomes disabled, recovery is less likely than for a younger worker. But even if recovery does occur, the older worker tends to be less able to find employment. Moreover, the elderly are often the victims of multiple impairments and their ailments tend to be compounded by the factor of age.

Overly-Hasty CDI Process Has Created Problems

The Social Security Disability Amendments of 1980 mandated that the Social Security Administration (SSA) commence a three-year review of all non-permanently disabled recipients in 1982. (Permanently disabled recipient review would start in 1985). In order to achieve quick budget savings, the Reagan Administration moved the start of the review ahead by nine months.

Only 160,000 disability cases were reviewed annually before 1981, but starting in FY81 SSA sent more than 300,000 cases to state agencies to review and plans to review an additional 567,000 cases in FY82 and 840,000 in FY83. This is in addition to the 160,000 cases already reviewed by social security which will also be ongoing.

We doubt that there is any Member of Congress who is not aware of the tragic consequences that have occurred as a result of the CDI's. The overly hasty implementation of this procedure left inadequate time to provide sufficient staffing and develop proper review procedures. Present state agency personnel are extremely overburdened with a backlog of case files. This situation has led to chaos and improper termination of benefits for thousands of disabled persons, many who have been on the rolls for a number of years.

Benefits are being terminated in more than 45% of the cases reviewed which greatly exceeds the 20% originally predicted by SSA. In addition to losing their benefits, many disabled have lost their homes, personal possessions, and in some instances, their lives. Although many will have their benefits restored on appeal (the current rate of reversal is about 60%), the financial losses suffered are irretrievable. Many of the people who are unjustly terminated from benefits are people who are aged and who have limited education. They often lack the sophistication necessary to fully understand their appeal rights or to seek counsel. Thus, many beneficiaries are unjustly terminated from the rolls because of this overly aggressive state agency review.

An additional problem with the CDI process is that recipients are being terminated without substantial medical evidence of improvement to support the decision. The poor development of records is due in part to extremely large state agency workload, understaffing, and arbitrary time constraints imposed for processing cases. The sheer volume of cases precludes the attentiveness necessary to a careful decision. The medical evidence is therefore usually incomplete and not current.

Recommendations on CDI Process

In order to assure that only non-disabled recipients are terminated from the rolls, it is necessary that there be an immediate slow down in the volume of cases subject to the CDI process. A reduced work load upon state agencies is necessary until staffing is adequate to meet case work loads and adequate procedures are implemented to assure quality reviews.

AARP also believes that there should be evidence of medical improvement prior to the termination of benefits unless there is evidence that the initial decision was clearly erroneous.

Inadequate Use of Consultative Examinations

There is also evidence that the state agencies rely heavily on consultative examination reports rather than on treating source reports. Both case law and SSA indicate that the most desired and trustworthy evidence is that of a treating physician eminently familiar with the claimants' maladies. The state agencies, however, appear to give more credibility to the consultative examination reports which are done by volume providers who perform cursory examinations. SSA has also failed to impose controls on these providers and that has perpetuated inadequate and incomplete examinations and records.

In the case where a treating physician's report is available, we believe state agencies should be required to rely primarily on that source to support the disability claim. If the consultative examiner's report is the only medical document which supports the termination of benefits, it is critical that the examination be complete and standards be imposed that set forth minimum requirements for consultative examinations to assure quality reports.

Strengthening the Reconsideration Level

Another area of concern in the disability program occurs at the reconsideration level. Representatives Pickle and Archer attempt to strengthen the appeals process, especially at the reconsideration level, through various provisions in H.R. 6181, the Disability Amendments of 1982. One such provision would extend the time period in which an applicant must request a reconsideration of his initial decision from 60 days to 180 days. AARP views this as a positive step in that it allows individuals to try to work but if they find themselves too disabled, the longer time period will most likely still give them time to appeal.

H.R. 6181 intends to make the reconsideration level more meaningful by providing face-to-face hearings commencing in January of 1984 for terminations based on medical reasons. Unfortunately, H.R. 6181 would also prohibit the introduction of additional evidence after the reconsideration level. The provision of a face-to-face hearing, in our opinion, is not an adequate substitute for the prohibition against additional evidence. Because of the complex nature of meeting disability standards, many individuals do not understand the importance of seeking counsel until the Administrative Law Judge (ALJ) hearing and therefore tend to develop inadequate records at the state level. State agency personnel are often overburdened and generally do not assist claimants in developing substantial records or in obtaining necessary medical evidence. In addition, unless the state agency personnel has the autonomy that is currently accorded the ALJ's, it is unreasonable to expect the use of fair and impartial procedures. Prior to accepting the provision that would close the record at the reconsideration level, additional assurances are necessary to insure that complete and adequate records are developed at this stage.

AARP therefore believes that the opportunity to submit additional evidence at the ALJ level should be maintained or the reconsideration decision should be made by independent adjudicators who would have responsibility to develop complete records after face-to-face interviews with the claimant.

Extending the Payment of Benefits

Under current law, when SSA determines that a beneficiary is no longer eligible for benefits or is otherwise ineligible, there potentially could be the payment of benefit for one additional month after the initial decision. H.R. 6181 addresses the financial hardships that beneficiaries may encounter by allowing the receipt of benefits for a maximum of six months while they appeal the initial decision. Although extending the payment of benefits up through the reconsideration level is laudable, it does not go far enough. The reconsideration determination occurs shortly after the initial decision but a much longer period passes between the reconsideration level and the ALJ hearing. Beneficiaries, many of whom are inappropriately terminated, lose their benefits and suffer irreparable financial injury while waiting for the appeal decision. AARP, therefore, favors extending the payment of benefits through the Administrative Law Judge (ALJ) level, a most crucial period.

Standards for Determining Disability

In adjudicating disability claims, state agencies, ALJ's and the Appeals Council are governed by the Social Security Act, the Code of Federal Regulations, the Social Security Rulings, and Supreme Court decisions. The Rulings amplify SSA policy and provide interpretations of the Act and Regulations. In order to clarify all of these for state disability adjudicators, SSA issues to them a detailed set of administrative instructions known as the Program Operating Manual System (POMS). They set forth the objectives of the disability program and standards with which the state agencies must comply in reaching a disability decision. Although the POMS contain the guidelines to be used in determining disability, it does not have the force or effect of the law and therefore is not binding on ALJ's or the Appeals Council.

The POMS are neither published nor subject to rulemaking procedures under the Administrative Procedure Act (APA), and are often at variance with the standards set forth in the Social Security Act, Regulations, and Rulings. H.R. 6181 proposes to make the POMS binding on ALJ's. Although this appears to be a minor provision, it would have the major effect of allowing the Social Security Administration to set more rigorous standards of disability, without the benefit of public comment or scrutiny of Congressional review. AARP feels that all adjudicative standards that affect substantive rights should be promulgated through notice and comment rulemaking as required under the APA.

Conclusion

In conclusion, AARP would like to thank this Committee for holding hearings on an issue that is of paramount concern to the Association. We urge you to recognize the problems with the administration of the disability program and to make a maximum effort to correct the procedures and standards which result in denying benefits to individuals who are truly disabled and in dire need of their benefits. The implementation of the several measures which we, along with some Members of Congress, have recommended should improve the quality of the program, restore confidence and equity to its administrative procedures and allay many fears expressed by its recipients.

TESTIMONY

on

SOCIAL SECURITY ADMINISTRATION'S CONTINUING DISABILITY INVESTIGATIONS

before

THE COMMITTEE ON FINANCE
UNITED STATES SENATE

on behalf of:

American Foundation for the Blind
Association for Retarded Citizens
Epilepsy Foundation of America
National Association of Private Residential Facilities
  for the Mentally Retarded
National Easter Seal Society
National Mental Health Association
National Multiple Sclerosis Society
National Society for Children and Adults with Autism
United Cerebral Palsy Associations, Inc.
Paralyzed Veterans of America

Witness:

Elizabeth M. Boggs, Ph.D.
Member, Governmental Affairs Committee
Association for Retarded Citizens

Wednesday, August 18, 1982

Those of us who share with members of this Committee a committment to maintain the Social Security system as a sound, fair and adequate social institution welcome your decision to hold this oversight hearing at this time.

Over the past several months the crescendo of protest over the massive terminations from the disability rolls has begun to be reflected in the pages of the Congressional Record and in the spate of bills cosponsored by many of your colleagues, who seek to redress the injustices of a system now become "uncontrollable" in reverse gear. It will not be our purpose to add more anecdotes to the stories of human distress recounted by the press and in your mail, or already on the record of other Committee hearings in the Senate or House. Rather we wish to take this opportunity to point up what to us appear to be aberrations in public policy, systems management, and in administrative compliance with the spirit and letter of the law. These aberrations underlie the individual human crises and will repeat and perpetuate them if not addressed.

FIRST THINGS FIRST

Several Senators have concluded that there is a disability crisis requiring some immediate action on a short range basis, to be followed by some more careful long range adjustments to the Social Security Act. We agree with them. These short range remedies cannot and should not wait for the report of the National Commission on Social Security Reform since they are issues of equity and due process not primarily associated with the issues of trust fund reserves (short or long range).

We believe that action must be taken at once to assure the following with respect to redeterminations (CDI):

1) Benefits will not be discontinued until an appeal, if taken timely, has been denied at the ALJ level.

2) No current SSDI or SSI beneficiary will be terminated without a clear finding that either (a) there has been medical improvement to the extent that the individual no longer meets the disability tests, or (b) the original decision was patently erroneous.

3) The process of redetermination is slowed down so that it can be conducted fairly and accurately, by adequately trained personnel, with respect for due process. There must be time for disabled persons to respond to the demands of SSA. There must be time for quality work. Quality work is not possible when SSA and DDS staff are subject to unreasonable workloads. We recommend a 5 year periodicity for those who are diaried.

4) No rules will become binding on DDS or ALJs until after publication and opportunity for public comment.

Secretary Schweiker and Commissioner Svahn have already made clear that they support extending the benefits of "certain" beneficiaries at least through the first appeal stage; they also favor allowing face-to-face contact at reconsideration rather than waiting until the ALJ hearings. GAO has expressed the view that Congress should clarify its intent with respect to "medical recovery" or improvement as it relates to redetermination of continuing disability.

We urge your immediate attention to these crisis issues.

RECENT ACTIONS BY SSA

On March 16th Commissioner Svahn testified before the House Ways and Means Subcommittee on Social Security. The official summary of his remarks on SSA actions to improve the DI program is appended.

In April SSA Associate Commissioner James S. Jeffers met with representatives of many organizations of and for disabled people. He gave further assurances along the following lines:

1) Benefits will continue to the due process final date and beneficiaries will no longer be expected to repay benefits made by SSA error.

2) The list of permanent impairments will be expanded.

3) State agencies will be required to obtain medical documents of record for each review, or document reasons why they cannot do so. They must also give specific information on each individual's impairment or lack thereof.

4) More thorough investigations will be made in cases of mental illness or retardation.

5) More federal reviews will be made of the result of DDSA redeterminations (CDIs).

6) Federal evaluations will be made of methods used by state agencies to contact personally each person under review.

7) A continuing series of meetings will be held with

disability groups to keep them informed of SSA policies as well as to receive their comments.

8) A new set of improved guidelines for conducting CDIs will be published and sent to state agencies soon.

We appreciate this evidence that SSA has at least recognized that many disabled people who are entitled to DI or SSI (or both) have been victims of the system and that "reform" should not be equated merely with "throwing the bastards out" but must also address prompt allowances and harassment-free maintenance of benefits to those entitled to them.

Despite these present and proposed reforms, we believe that the crisis is deeper than has been realized to date. It is not limited to CDIs or to Title II. It affects new applicants and SSI eligibles as well. We are receiving ominous reports that disabled SSI recipients are also being terminated abruptly, and that some are being reinstated 6-10 months later either without retroactive payment or with the lump sum payment being considered windfall income in the month received. This is a brutal way to save money.

POLICY ISSUES - THE POLITICS OF CUTTING BACK.

As your Committee is painfully aware a program which involves five million people cannot be cut significantly without some fanfare. The political choice is between cutting many people a little, or a few people a lot - maybe eliminating a whole segment. Politically shafting a few may be safer than offending many with more moderate modifications.

Despite much discussion of impending adverse dependency ratios and their impact on the cash flow in OASDI, little has been done to curtail the benefits of present or prospective ordinary retirees. In the meantime much is being done to curtail the relatively smaller disability program, not only by curtailing benefits selectively as was done in 1980, but by targeting many people for ejection or rejection entirely. For them it is not a statistical 10 or 20 percent reduction but 100 percent. The more subtle form of this political strategy is to exclude now those who might have become eligible in the future but are not counting on it.

This Committee, even more than most, understands the meaning of "hold harmless". It is a long standing principle of politics that from him who hath and knows that he hath, nothing may be taken, but from him who hath but knows it not, even that which he hath may be taken away with impunity. Following an adage which describes the undergraduate collegiate hierarchy in somewhat similar language, I shall call those who know what they have (or believe they are about to receive) as "seniors", and those who have but don't know it "sophomores". People who are receiving social security benefits, whether as retired workers, as their auxiliaries or as disabled workers, know what they have, including at least in principle, their COLA. So do people who are approaching the magical age of 62. That became evident a year ago, when President Reagan suggested making early retirement less attractive. Similarly in 1977 it was necessary to assure that the reforms then instituted would be phased in over some 5 years, lest decoupling dash the expectations of those whose aspirations had been raised in the early '70's.

But people who will become disabled in the future usually do not know it. They are the sophomores. They do not know the extent and value of the disability coverage they have built up, nor how essential it may be to their protection if disaster strikes. Taking away their benefits before the moment of entitlement is like taking candy from the proverbial baby.

We are here to speak for disabled people, both the seniors and the sophomores. You have been getting letters from the seniors (or at least from the more vocal of them) who are being targeted in the continuing disability investigations. You knew that you would. In announcing this hearing the chairman referred to the "confusion and understandable concern on the part of people now receiving disability benefits". The fact that you expected some remonstrances should not be allowed to deaden your sensitivity to real and valid complaints about the fairness of the procedures, the correctness of the findings in particular cases, and the hardships being imposed on some individuals.

Others on this panel are speaking particularly to the intense experience of people who are terminated due to alledged "recovery". They are the center of the firestorm. While affirming our concern about these identifiable persons, we wish to stress particularly the needs and rights of the "sophomores"- those who do not know that, unless you act, SSA will not, after all, be there when they need benefits because of an unforeseen premature, long term or permanent extrusion from the labor force.

TRENDS SINCE 1970 - THE CRESCENDO OF THE MID '70s

Congressional and administrative concerns about the DI program go back to the mid-seventies when the rolls increased quite dramatically over a five-year period. There has been considerable speculation on the cause or causes of this phenomenon but, in our opinion, no adequate analysis of the relative contribution of various convergent factors. More particularly it seems to us that these factors have not been clearly classified in such a way as to indicate which were adventious and peculiar to that era, which were to be expected from demographic considerations, which could be properly remedied by better management, which required policy review by the Congress, and above all what should be considered reasonable on-going rates for allowances, terminations and numbers on the rolls. Where some of these factors have been addressed it has usually been on a single assumption and not on an interactive or systems basis.

Among the explanations that have been advanced for the peaking of DI applications and allowances in 1975 are:

1) The economic recession in 1974-1977.
2) Outreach by SSA in connection with initiation of the SSI program, which outreach allegedly encouraged applications by handicapped people who were not "severely impaired".
3) The greater public acceptance of government aid.
4) The overload on the disability determination machinery as a result of assimilation of the SSI program, allegedley leading to shoddy work on allowances during this period.

Among the factors given less attention have been:

5) The cumulative effect of the return of Vietnam veterans. This was the first major cohort of veterans to have had contributory OASDI coverage while on combat duty. In addition to those who returned with disabilities, many of them have since developed psychiatric disorders or neurological problems which have not necessarily been accepted as service-connected.
6) The effect of SSI enrollment on severely disabled persons under 65 who were not aware of their eligibility for small DI benefits based on an irregular earnings record; these entitlements were disclosed and claimed when the SSI claim was processed.
7) The concurrent effect of liberalizing the requirement for the number of quarters of coverage for young

disabled workers at a time when a quarter could be earned on as little as $50.00 in covered wages.

8) The age specific effect of having in 1975 a particularly large cohort of persons between 50 and 65 (born between 1910 and 1925), an age range in which one expects the incidence of disability to increase markedly.

9) The rise in the number of people in this age range who are insured for disability.

In reviewing these considerations one by one and considering the degree to which each might or might not be expected to apply today we note the following:

1) The present recession is more pronounced than was that of the mid-seventies.

2) If SSA outreach did bring in inappropriate applications which did indeed get through the screen, the effects should have stabilized by now. More than half of those awarded benefits in 1975 will have died or been converted to OASI by the end of this year.

3) Increased respectability of legitimately eligible persons receiving benefits was an objective of the SSI program and should continue as such but is probably suffering set-backs now as a result of publicity about "the disability mess".

4) The notion that somehow SSA's disability determination system let down its guard and allowed itself to be raped in 1975 is not consistent with the fact that the

allowance rate at the initial level was only 40 percent in 1975 compared to 44 percent in 1970. Since then, initial denials have gone from 60 percent in 1975 to 67 percent in 1980 and confirmation of those denials referred for reconsideration has increased from 67 percent to 85 percent. With this escalation of denials it is scarcely surprising that appeals from the reconsideration step to ALJs have both increased and become somewhat more successful.

This is not necessarily deplorable since the ALJ system was put in place to provide a review independent of SSA, using administrative due process, in lieu of judicial due process, while leaving the courts as a last resort. (See later discussion of "Bellmon Report".)

5) Those Vietnam veterans already on the rolls with permanent disability will affect the caseload for about 40 years. Even though the risk of subsequent disability may be heightened by active duty, as time goes on new accessions of middle aged and older veterans should reflect more nearly the experience after World War II since those who reenter the civilian work force can acquire insured status independent of military duty.

6) That many DI eligibles were unaware of their eligibility in 1974-1975 is supported by specific studies on this point in the 1974 follow up study of the 1972 disability

survey which showed that 33 percent of the severely disabled were receiving benefits, but that 42 percent were unaware of the program and 24 percent, though aware, had not applied. The one-time incremental effect on the DI allowance rate in 1974-1976 which accompanied initiation of SSI will not be repeated. However, the proportion of disabled worker recipients who also receive SSI appears to be about ten percent or about 275 thousand currently.

7) The windfall for younger workers with very low coverage was remedied by the 1977 amendment which increased the minimum earnings required for a quarter of coverage; in addition the deliberalization of "drop out" years in 1980 and the more recent removal of the minimum benefit have diverted new cases of this sort, although many younger workers who were legally enrolled in the mid-seventies will continue as beneficiaries for some years to come.

8) The expanded cohorts of those born between 1910 and 1930 are still impacting the critical disability age group 50-65 and will continue to do so, although the cumulative effect on the DI program would be expected to subside beginning in the mid-80's. Indeed this demographic fact was presumably a major factor for the 1977 prediction by SAA that disability rolls would continue to rise until 1986 at which time they would peak at a level about one-third above 1977.

There is an additional demographic factor to be noted here. Among older people present criteria include consideration of educational factors. This is a realistic reflection of the capacity for work of a person who is both impaired and under educated. The people who in 1975 (or today) are 60 plus 5 years old were of high school or college age during the depression of the '30's. This cohort lacks the educational attainment of those that preceded it as well as those who follow. This was specifically illustrated in the 1972 disability survey.

9) The number of persons insured for disability has continued to increase. The number of persons filing applications in 1982 is expected to total about 1.3 million, close to the 1975 level. The number of people in the most vulnerable age range has increased (19.7 million in 1975, 21.7 million in 1980). The full implications of this phenomenon are discussed in the next section.

Reviewing all these factors together qualitatively suggests to us that had 1977 allowance parameters continued to be applied with reasonable accuracy and consistency, rolls would have increased at least another 10-15 percent by now. Allowing for a 10 percent retrenchment to cover the legitimate effect of a more diligent search for recovered beneficiaries through CDI, an essentially level or slightly increasing enrollment might have been anticipated until 1985. Instead, the rolls are declining.

TRENDS SINCE 1975 - WHAT IS HAPPENING NOW

The most striking recent statistic is the dramatic decline in new allowances since the peak in 1975. The 1981 rate was 3.62 per thousand insured, half the rate of 7.11 in 1975, and it appears to be continuing its downward plunge. This is the lowest rate in the 25 year history of the program (Table 1).

Because this gross rate is not age adjusted we examined the age-specific incidence rates for 1975 and 1978 (latest available). Whereas the overall rate declined about 27 percent in the three-year period, the age specific rate declined about 23 percent for younger age groups and 25 percent for older workers (Table 2).

Because so many people are now taking early retirement (and hence are no longer in the denominator of the incidence equation) we also examined the data on prevalence, i.e., the number of disabled workers age 62-64 who were on the DI rolls between 1970 and 1981 as a percentage of those eligible (i.e., those working plus OASDI primary beneficiaries in this age group). Table 3 indicates that (1) the number of disabled workers in current payment status as a percent of eligibles peaked in 1979 and is now declining while the percent of retired workers continues to increase, from 40.6 in 1979 to 43.1 in 1981. The conclusion we have to draw is that significant numbers of people in their 60's are being denied or terminated for DI but are nevertheless having to retire early on OASI. While forcing them to take actuarial reduction in individual benefits may save some money, this intercategory transfer is scarcely a triumph for the disability purge, even if it appears to cleanup the books.

TERMINATIONS

SSA does not publish termination data in its regular monthly bulletins. Moreover, to understand what is occuring one must have a breakdown by cause. Most terminations are due to (1) conversion to OASI at age 65, (2) death, and (3) "recovery". In 1976 these accounted for 49 percent, 39 percent and 10 percent respectively of the 351 thousand DI workers terminated that year. The death rate has been steadily declining despite the demographic shift mentioned earlier. Conversions should remain relatively high until the early 90's unless older disabled people are forced off the DI rolls prematurely. The serial data on "recoveries" is marked by inconsistencies in reporting codes, but it is clear that numbers so recorded have been increasing in the past five years even before the stepping-up of CDI's beginning in March 1981.

Not only are there declines in incidence and age specific prevalence, but prevalence and numbers of DI worker beneficiaries of all ages have been coming down since 1978 (Table 4). The still more dramatic decline in the numbers of minor children of DI workers appears to reflect primarily the graduation of the baby boom cohorts. While fiscally favorable, it is not a variable subject to direct administrative control, although we understand that disabled workers with families have been targeted for CDIs.

In short the evidence we can deduce from the readily available published data leads us to conclude not only that CDIs are resulting in excessive and ill considered terminations but that new applicants for both DI and SSI are being denied at an unprecedented rate. Because of the current and projected demographic profiles we would expect a maintenance or even a modest increase in incidence and prevalence of DI allowances and current payees even without assuming that a reduced death rate means an increased longevity for disabled people. Instead both are declining.

The variety of factors contributing to the net gain or loss in beneficiaries in any year requires disaggregation by cause. We urge you to prevail on SSA to publish current figures on a quarterly basis covering persons on DI worker rolls whose status has changed during the year, broken down by termination type (as above), appeal and payment status, and broad age group . We also believe that timely indicative data on initial denials and on appeals by new applicants should be made available to you and us, including trends in pre-effectuation review of both allowances and denials.

Much damage could be done if this pre-effectuation process receives no objective evaluation prior to the report which Congress has required be prepared by January 1, 1985. We believe SSA should give special attention to quality control on denials which involve multiple impairments and those disorders which characteristically fluctuate in functional effect, such as multiple sclerosis and schizophrenia. Our anecdotal reports support the notes on these topics presented by Mr. Ahart, the Director of GAO, at the hearing before the Senate Committee on Government Affairs on May 25, 1982.

THE BELLMON REPORT

During the Carter administration ALJs became a target of complaint by the Department of Health and Human Services and the Social Security Administration; the Congress concurred by adding Section 304 (g) to the Social Security Amendments of 1980. This amendment required the SSA to institute a program of ongoing review of ALJ decisions and to submit to Congress last January a report on that review and on a study of factors that influence ALJ decisions. It is said that the request for this report "arose from Congressional concern with the increasing number of denials being appealed to ALJs and the high percentage of DDS denials that were being overturned by ALJs". The report deals with the latter but not the former.

You now have this report; more recently it has become available to the public through publication in the May 1982 Social Security Bulletin. We believe that the study on which the report is based was well designed and the results useful. There are, however, some inferences to be drawn from this study that have not been highlighted sufficiently.

In the words of the report itself:

> The initial review was based on a sample of 3,600 recent ALJ decisions on disability cases. The case folders were reviewed by two different units within SSA: the Office of Assessment (OA), which operated under the standards governing the DDSs, and the Appeals Council which applied the standards and procedures governing ALJ decisions. Each unit made new decisions on each case without being aware of the original ALJ decision or the decision of the other reviewing organization. These new decisions were used only for analytical purposes; they were not used to actually alter the original ALJ determination.
>
> The major finding of the initial review was that significant differences in decision results were produced when these different decisionmakers were presented with the same evidence on the same cases. The ALJs allowed 64 percent of the cases. The Appeals Council, applying ALJ standards, allowed 48 percent. OA, applying DDS standards, allowed only 13 percent.
>
> An examination of the standards and procedures governing the ALJs and DDSs indicates distinct differences. In certain instances, operational definitions are not identical. In other instances, ALJ procedures permit a finding of disability that is not possible under the DDS standards. Finally, in some areas the definitions contained in the standards are the same, but procedures differ for evaluationg evidence of impairment.

Our observations are as follows:

1. In the test situation the Office of Assessment reviewers used the more detailed and explicit rules and POMS which were considered binding on the DDS agencies but not ALJs. OA then "allowed" 13 percent of those cases denied at the initial (state DDS) level. This figure is based on a sample taken before the recent intensification of pressure on the DDS to become more strict, to place less emphasis on vocational factors, etc. While this reversal rate is less than the ALJ

or Advisory Council rates (based on more general rules) it still represents an unacceptable "error rate" for the DDS level. It also suggests that DDS staff may be playing it on the safe side for themselves by favoring denials on the assumption that the client can appeal any denial. This is distinctly unfair not only to those who do appeal but to those who are denied and do not have the wit or resources to appeal. Appeals are costly to everyone. The system should be structured to maximize correct first decision and minimize the perceived need to appeal.

2. There is strong evidence that face-to-face contact and full information improves a client's prospects for success at the ALJ level. SSA is considering permitting face-to-face contact at the DDS reconsideration level. We favor this change but caution that DDS personnel do not have the legal training and experience of ALJs. If reconsideration is to be a credible resource, staff who conduct reconsiderations should be shielded from a vested interest in protecting the initial decision.

3. The study was structured in response to a Congressional directive. The assumption behind the directive was clearly that ALJs are "out of line"; the study was not designed to evaluate the performance of DDS reviewers as such. Moreover, the assumption appears to be made that, because the POMs and other directives used at the DDS level are more detailed and precise, they are also more likely to produce "correct" as well as

consistent results. From this it is inferred that ALJs must be required to comply with them. Yet it is quite possible that experienced ALJs may be more "correct" than initial reviewers at the state level. We have grave questions as to whether the Social Security rulings and other guidance, much of which is not put out for public review, in fact conform fully to the statutory language and intent.

We trust that current efforts for regulatory reform do not result in a regulatory underground of invisible rules.

Table [illegible]1
NUMBER OF AWARDS AND INCIDENCE RATES FOR DISABLED-WORKER BENEFICIARIES, 1957-80*

Calendar Year	Number Insured on January 1 (in millions)	Number of Awards During the Year (in thousands)	Incidence Rate (per thousand)
1957	10.00	179	17.90
1958a/	10.36	131	13.79
1959a/	11.78	178	13.95
1960	46.36	208	4.49
1961	48.51	280	5.77
1962	50.47	251	4.97
1963	51.52	224	4.35
1964	52.30	208	3.98
1965	53.32	253	4.74
1966	54.99	278	5.06
1967	55.72	301	5.40
1968	67.96	323	4.75
1969	70.12	345	4.92
1970	72.36	350	4.84
1971	74.50	416	5.58
1972	76.14	455	5.98
1973	77.80	492	6.32
1974	80.44	536	6.66
1975	83.27	592	7.11
1976	85.15	552	6.48
1977	86.65	569	6.57
1978	88.83	457	5.15
1979	90.60	409	4.51
1980b/	93.10	390	4.19
1981	95.2	345	3.62

a/For statistical purposes, the years 1958 and 1959 were defined as covering the periods January 1, 1958 to November 30, 1958 and December 1, 1958 to December 31, 1959, respectively. However, the gross incidence rates are shown after conversion to an annual basis.

b/Estimated by the Office of the Actuary, Social Security Administration.

*From Actuarial Study No. 81, Social Security Administration, April 1980.

From report of the National Commission on Social Security p. 197
a updated with data from the Social Security Bulletin Annual
Statistical Supplement 1980 and Social Security Bulletin June, 1

TABLE 2 - AGE SPECIFIC INCIDENCE:* DISABILITY AWARDS

Age group	1975 Awards per 1000 insured	1978 Awards per 1000 insured
Under 25	1.00	.77
25 - 29	1.89	1.37
30 - 34	2.59	1.88
35 - 39	3.45	2.68
40 - 44	5.02	3.90
45 - 49	7.50	5.66
50 - 54	12.21	9.37
55 - 59	20.05	15.07
60 - 64	29.53	21.07
Total	7.11	5.22

* Number of awards in year per 1000 living workers insured for disability at beginning of year (estimated).

Source: Social Security Bulletin Annual Statiscal Supplement 1975, Table 71.

Social Security Bulletin Annual Statiscal Supplement 1980, Table 44.

TABLE 3 - PREVALENCE OF DISABLED AND RETIRED BENEFICIARIES AGED 62-64 : 1970-1981

Column A: Number of disabled worker beneficiaries as percent of all eligible persons age 62 - 64 at beginning of year *

Column B: Number of beneficiaries receiving early retirement benefits as percent of all eligible persons age 62 -64

Column C: Number of all disabled and retired worker beneficiaries as percent of eligible persons age 62 - 64

	A	B	C
1970	8.3	30.9	39.4
1971	8.5	32.2	40.6
1972	9.0	34.0	43.0
1973	9.8	36.0	45.7
1974	10.3	38.1	48.3
1975	11.1	39.2	50.3
1976	12.1	40.6	52.6
1977	12.7	40.1	52.7
1978	13.2	41.3	54.5
1979	13.3	40.6	53.8
1980	13.2	41.8	55.0
1981	12.9	43.1	56.0

* Number eligible is estimated.

From data contained in Table 46 - Social Security Bulletin, Annual Statistical Supplement, 1980

Table 4- Disabled workers and auxiliaries : 1957-82

Number in current payment status.

At end of selected month	Total	Disabled workers [1]	Wives and husbands [2]	Children [3]
December:				
1957	149,850	149,850	....	....
1958 [4]	268,057	237,719	12,231	18,107
1959	460,354	334,443	47,914	77,997
1960	687,451	455,371	76,599	155,481
1961	1,027,089	618,075	118,187	290,827
1962	1,275,105	740,867	147,066	387,172
1963	1,452,472	827,014	168,243	457,215
1964	1,563,366	894,173	179,344	489,849
1965	1,739,051	988,074	193,362	557,615
1966	1,970,322	1,097,190	219,559	653,573
1967	2,140,214	1,193,120	234,550	712,544
1968	2,335,134	1,295,300	253,198	786,636
1969	2,487,548	1,394,291	264,340	828,917
1970	2,664,995	1,492,948	283,447	888,600
1971	2,930,008	1,647,684	311,581	970,743
1972	3,271,486	1,832,916	350,139	1,088,431
1973	3,558,982	2,016,626	381,079	1,161,277
1974	3,911,334	2,236,882	411,660	1,262,792
1975	4,352,200	2,488,774	452,922	1,410,504
1976	4,623,827	2,670,244	473,909	1,479,674
1977	4,854,206	2,834,432	494,389	1,525,385
1978	4,868,576	2,879,828	491,535	1,497,213
1979	4,777,218	2,870,411	475,493	1,431,314
1980	4,682,172	2,861,253	462,204	1,358,715
1981	4,456,274	2,776,519	428,212	1,251,543
1981				
February	4,691,078	2,854,519	459,745	1,376,814
March	4,693,498	2,851,342	457,881	1,384,275
April	4,687,540	2,847,434	455,945	1,384,161
May	4,674,522	2,840,134	453,367	1,381,021
June	4,635,831	2,835,471	450,338	1,350,022
July	4,580,680	2,827,181	447,493	1,306,006
August	4,556,817	2,814,150	443,011	1,299,656
September	4,534,740	2,804,617	438,789	1,291,334
October	4,512,870	2,795,892	434,873	1,282,105
November	4,484,417	2,786,712	431,649	1,266,056
December	4,456,274	2,776,519	428,212	1,251,543
1982				
January	4,414,245	2,759,794	422,139	1,232,312
February	4,385,886	2,744,856	416,870	1,224,160

Number of new awards

Period	Total	Disabled workers [1]	Wives and husbands [2]	Children [3]
1957	178,802	178,802	....	....
1958	162,566	131,382	12,920	18,264
1959	310,765	177,811	54,299	78,655
1960	366,302	207,805	54,187	104,310
1961	546,629	279,758	77,588	189,283
1962	490,200	250,634	69,212	170,354
1963	454,249	223,739	66,543	163,967
1964	412,737	207,592	59,706	145,439
1965	520,298	253,499	69,183	197,616
1966	636,009	278,503	81,284	276,222
1967	671,317	301,359	87,296	282,662
1968	711,773	323,154	89,603	299,016
1969	753,060	344,741	94,690	313,629
1970	763,234	350,384	96,304	316,546
1971	901,343	415,897	113,222	372,224
1972	991,570	455,438	124,366	411,766
1973	1,033,565	491,616	128,198	413,751
1974	1,111,928	535,977	132,042	443,909
1975	1,256,006	592,049	148,741	515,216
1976	1,210,732	551,740	147,433	511,559
1977	1,239,445	569,035	151,936	518,474
1978	1,045,507	457,451	130,192	457,864
1979	921,213	408,680	113,101	399,432
1980	883,984	389,152	108,502	386,330
1981	787,328	345,254	96,207	345,867
1981				
February	70,945	30,535	8,563	31,847
March	81,298	34,384	10,046	36,868
April	64,491	28,361	7,803	28,327
May [4]	89,839	39,248	11,351	39,240
June [5]	33,977	15,581	3,660	14,736
July	65,667	29,175	8,208	28,284
August	61,021	27,254	7,711	26,056
September	64,624	28,882	7,778	27,964
October	66,425	29,173	7,960	29,292
November	62,982	28,124	7,745	27,113
December	56,097	24,829	6,969	24,299
1982				
January	62,562	28,317	7,601	26,644
February	56,319	24,565	6,616	25,138

[1] July 1957-October 1960, disabled workers aged 50-64, beginning November 1960, disabled workers under age 65.

[2] Mainly wives under age 65 with entitled children in their care.

[3] Includes, beginning 1957, disabled persons aged 18 and over whose disability began before age 22 (age 18 before January 1973) and, beginning September 1965, entitled full-time students aged 18-21. Beginning January 1973, students who attain age 22 before end of semester may continue to receive benefits until end of semester.

[4] Includes a significant number of awards at the pre-June benefit rates that would normally be included with the June figures.

[5] The June awards include only those with the new benefit rates.

Adapted from Tables M-12 and M-17

Social Security Bulletin, June 1982/Vol. 45, No. 6

From Appendix

SUMMARY OF TESTIMONY
Social Security Commissioner John A. Svahn
March 16, 1982
House Ways and Means Subcommittee on Social Security

Social Security Disability Program

- Deep-seated and long-standing problems in many areas of the program have been documented. The 1980 disability amendments made important improvements.
- The Administration has been moving aggressively to address problems administratively, using four objectives:
  - --Ensure that all claimants who are disabled will be found entitled to benefits, those not disabled will be denied benefits, and that beneficiaries no longer disabled will be removed from the rolls.
  - --Process claims timely at initial and appellate levels.
  - --Treat similar claimants uniformly throughout the country at all levels of adjudication.
  - --Use high quality medical evidence.
- To achieve these objectives, SSA is:
  - --Changing the way of determining when beneficiaries have medically recovered. When the system is at fault in delaying the determination, the person generally will be considered to have recovered when the continuing disability determination is made. No repayment of benefits paid before then will be required. If delay is clearly fraud, however, SSA will make a retroactive determination of medical recovery and prosecute fully.
  - --Currently reexamining all disability beneficiaries.
  - --Expanding the use of Social Security Rulings to assure uniform nationwide application of adjudication standards.
  - --Reviewing a sample of initial denials as well as approvals.
  - --Doing own-motion review of ALJ allowances, since October 1, 1981.
  - --Testing ways the State DDS reconsideration process might be improved.
  - --Expanding the ALJ corps and support staff to reduce backlogs and speed processing
  - --Introducing innovative processing techniques in hearing offices, new equipment to increase productivity, and improved training.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
SOCIAL SECURITY ADMINISTRATION

OFFICE OF
HEARINGS AND APPEALS

Treasure State Bldg., Suite 204
2906 - 2nd Avenue North
Billings, Montana 59101
Phone (406) 657-6142

REFER TO:

August 13, 1982

Hon. Pat Williams
U. S. HOUSE OF REPRESENTATIVES
Washington, D. C. 20515

Dear Mr. Williams:

At the Subcommittee (veterans) hearings in Helena, I pointed out several areas where the Congress has intentionally and wilfully "stuck it to" the citizen and/or assisted and permitted the bureaucracy in so doing. Subsequent to the hearing, The Montana Maverick asked me for a summary of my statement. Rather than try to again summarize it here, I will just enclose a copy of the statement printed by the Maverick.

I am also enclosing a copy of the Program Operations Manual System (POMS) pertaining to the Social Security Administration (SSA) having a representative present to present the SSA's side. (It appears that the SSA's representative may be an attorney or nonattorney, as is now true with respect to the claimant.) In particular, note that

1. The SSA representative will be an employee of the Office of Hearings and Appeals (OHA) -- which is part of the SSA. In other words, working for the same employer (SSA), etc., etc., as the Administrative Law Judge (ALJ) that will decide the case. Cozy?
2. The SSA's representative will be "stationed in the (OHA) hearing office". Cozier?

Note also the assertion that one purpose of the project is that of "reducing delays in hearings". When was the last time you ever heard that a hearing involving one judge, one claimant and one attorney or representative took more time than a hearing involving one judge, one claimant and two (2) attorneys/representatives?

Keep in mind that the idea of the SSA having a representative/attorney, making that person an employee of the SSA's OHA, placing that person in the same office as the SSA's own ALJ, etc., etc., was worked on and approved by career government lawyers of the OHA/SSA/HHS. They see no conflicts of interest, ethical problems, etc., etc., in having an attorney/representative for one of the parties to a lawsuit work for, with, etc., etc., the same organization and being in the same office as the judge who is supposed to provide a fair, impartial, objective, etc., hearing to both parties. That's the tragedy of the whole thing -- they honest to God do not see conflicts of interest, ethical questions, etc.

Some time ago I said that one of these days the bureaucracy will just simply decide that it has had enough of the Congress and enact some regulations to abolish it. (We may be one step closer.) I am enclosing an article from the Federal Times, August 16, 1982, which shows that the Department of HHS may just stop publishing some notices in the Federal Register, or, they may condescend to publish them only after they have taken effect. (Based on your experience, what do you think the chances are that any bureaucracy would actually put regulations into operation and then admit that they were wrong and withdraw them?)

In a recent article in the Federal Employees News Digest, August 2, 1982, Representative Edward Derwinski (R-Ill.) is quoted as saying:

> "...Federal annuitants will be better served in the immediate future by a cap on COLA than they would be by the abolishment or absorption of the civil service retirement program into the Social Security system, but what you are doing here is helping to build a case for the Ways and Means Committee which has botched and bungled the Social Security System for 45 years, to grab the federal retirement system and use it as a patch on social security. This is the thing federal employees and annuitants should fear the most."

I disagree with him only in that I would change "Ways and Means Committee" to read "the Congress". I would then add "And the Congress is still botching and bungling it."

Sincerely,

Don Edgar Burris
Administrative Law Judge

cc: Hon. John Melcher
Hon. Max Baucus
Hon. Ron Marlenee
Hon. Patrick Moynihan
Hon. Jake Pickle
Hon. Timothy Wirth
Members, Ways & Means Comm.

Program Operations Manual System
Part 02 - General
Chapter 031 - Appeals
Subchapter 09 - Disability Insurance Program
and Black Lung

* * *

NOTE: The audience for this entire supplement is the same: OS, OA, RR, FR, CR

T03109.200. SSA Representative Project

A. General

SSA will be conducting a project in which SSA will be represented at hearings involving the issue of disability by an SSA representative. The project will run for approximately 1 year and will involve five hearing offices within Regions III, IV, VII, and IX. The representative will be responsible for preparing the disability case for hearing. When the claimant has appointed a representative, the SSA representative will also participate in the hearing and in any post-hearing development approved by the administrative law judge. (The SSA representative's responsibility in cases involving claimants who have not appointed representatives will be limited to preparing the case for hearing.) Under these procedures, the claimant will retain all rights which are provided under the Social Security Act and current regulations, and the administrative law judge will retain the ultimate responsibility for conducting and controlling the hearing, for the completeness of the claims record, and for issuance of the hearing decision. When the claimant has appointed a representative, the SSA representative will have the same rights as the claimant except the right to appeal the hearing decision.

The purpose of the SSA representative project is to determine whether more uniform and consistent hearing decisions on the issue of disability will result from having a representative of SSA sharpen the issues, present the facts, and state SSA's position in a disability case to the administrative law judge. Other purposes for the project include improving the overall disability adjudicatory process and reducing delays in hearings. Because a primary function of the SSA representative will be to develop the claims record at the hearing level, the administrative law judge will be able to devote more time and attention to his or her primary tasks of conducting the hearing and issuing the hearing decision.

B. Included Cases

The project will include all cases in the selected hearings offices (see C. below) in which there is a request for a hearing on an issue of disability under title II and/or title XVI of the Social Security Act. It will include any such cases in which the claimant either has appointed a representative or is unrepresented (see D. below). Cases involving travel from the hearing office that necessitate per diem expenses will not be included, and all other cases will also be excluded.

C. Selected Hearing Offices

The project will be conducted initially in four regions and will involve five hearing offices and the district/branch offices serviced by those hearing offices. District/branch offices other than those serviced by the five selected hearing offices may also become involved when a hearing request is filed outside the claimant's resident office. If the claimant's resident office is serviced by one of the selected hearing offices and the case meets the criteria shown in B. above, it will be included in the project.

* * *

D. Represented and Unrepresented Claimants

The project will include all hearings cases which meet the criteria in B. above, whether the claimant is represented or unrepresented.

- Unrepresented Claimants - When the claimant has not appointed a representative, the SSA representative will prepare the case for the hearing, including obtaining any additional evidence and making any necessary contacts with the claimant. The SSA representative will have no further involvement with the case and will not appear at the hearing.

- Represented Claimants - Where the claimant has appointed a representative (see GN 03910.020 and GN 03920.030), the SSA representative will prepare the case for the hearing, including obtaining any additional evidence and making necessary contacts with the claimant's appointed representative. The SSA representative will also participate in the hearing and will initiate any post-hearing development approved by the administrative law judge. In addition, the SSA representative will send copies of any correspondence to the appointed representative.

E. Location of the SSA Representative

The SSA representative will be an OHA employee stationed in the hearing office.

FEDERAL TIMES, Aug. 16, 1982

Public Responds Angrily To HHS 'No Comment'

In late June, the Health and Human Services Department published a notice in the Federal Register for public comment. It said HHS may not be publishing some future notices in the Federal Register for public comment.

by early August, HHS had received 121 letters of comment. All of them were negative.

Many of the letters came from Florida, where retirees feared changes in social security and Medicare. Other letters came from lawyers in private practice, groups providing legal services to the poor, aged or mentally retarded, state agencies, hospitals, nurses, former civil servants and self-described disappointed voters.

Some letters decried a "power grab" by HHS and said the plan runs counter to Reagan administration promises to shift power from the government to the citizens.

The HHS notice asserts a right to make new rules regarding public property, loans, grants, benefits and contracts without public comment when "necessary or appropriate." The proposal would cover social security, Medicare, Medicaid and other HHS benefit programs as well as various project grants.

Technically, those types of rules already are exempt from the public comment requirements of the Administrative Procedure Act. But in 1970, HHS, then the Health, Education and Welfare Department, announced it would comply with the act voluntarily.

Because it is complying voluntarily, HHS says, it should not be held to the act's standards of allowing agencies to omit comment only when it is "impracticable, unnecessary, or contrary to the public interest."

The department says it would circumvent comment only rarely, such as cases where regulations must be issued quickly. When there isn't time to publish proposed rules for comment, HHS says, comments will be considered after the rules take effect.

Last year, for example, Congress changed some benefits under Aid to Families with Dependent Children on August 13 and HHS had to issue rules by the start of the fiscal year, October 1. A district court judge ruled that the rules were invalid because the public didn't have time to comment, but that decision was overthrown on appeal.

"That is what brought it to our attention," said Terry Coleman, the HHS attorney who supervises new regulations. "Part of the concern also was that courts have been gradually tightening the exemptions" under the Administrative Procedure Act.

The Federal Register notice says the proposal would "clarify that the Department's voluntary use of notice and comment procedures is not intended to create any judicially enforceable rights. ...when the Department finds it necessary to omit notice and comment procedures, the courts should not review that action as if the Department had been legally obliged to use notice and comment procedures."

HHS rules will be published for comment, the notice says, except when "the delay that would result would impair the attainment of program objectives or would have other disadvantages that outweigh

(See HHS, Page 22)

HHS

(From Page 3)

the benefits of receiving public comment prior to issuance of the rules."

Some in Congress read more into the notice. "I suspect this proposal amounts to a sneaky, back door method by the administration to reshape social program regulations to suit the administration's ends," said Rep. Dennis E. Eckart, D-Ohio.

Rep. Claude Pepper, D-Fla., chairman of the House select committee on aging, said the plan would allow far-reaching changes in benefits programs involving millions of people and billions of dollars "in a manner that turns a deaf ear to the concerns of those affected and the public as a whole."

The Senate already has passed a provision to eliminate the exemptions from comment under the procedure act as part of a regulatory reform bill. The bill is pending in the House.

Coleman said HHS went ahead with its Federal Register notice despite the bill because similar bills have been considered since 1970 without resolution. He said it is "certainly" possible that the proposal will be dropped even if the bill does not pass.

—YODER.

Special Letter to the Editor: An Insider Views the Bureaucrac

Dear Mr. Devitt:

This is to acknowledge and reply to your request for a summary of my statement before the Subcommittee on Oversight and Investigations of the U.S. House of Representatives Committee on Veterans' Affairs in Helena, Montana, June 19, 1982.

It has been a month since the hearings, therefore, the memory is entitled to be a bit rusty. For a fact, I do not recall all of my remarks, the order in which they were presented, etc. I do recall the following points.

First: I made it clear to the Subcommittee - and I wish to make it clear here - that, while I am an Administrative Law Judge (ALJ) with the Office of Hearings and Appeals (OHA), Social Security Administration - (SSA), Department of Health and Human Services (DHHS), I appeared before the Subcommittee solely as a private citizen and ex-Marine Staff Sergeant.

I also made it clear that I was not authorized to speak for, or in behalf of, the OHA, the SSA and/or the DHHS, and commented that this was agreeable with me as there was very little that they would say about me that was good and even less that I would say "good" about them.

Second: The most important point I made has to do with a very basic concept of American government and law, namely, the doctrine of separation of powers.

Every school kid in the United States is exposed to the idea of separation of powers from a very early age. The idea of having the Legislative (Congress) enact laws, the Executive carry them out and the Judiciary (courts) interpret them is truly one of the - if not the - greatest ideas and safeguards embodied in our Constitution.

While most Americans have faith in the Constitutional concept of separation of powers, the U.S. Congress does not.

For example, look at the number of bills now pending in Congress that would take away the jurisdiction of the courts to hear certain cases. Another illustration is the fact that when Congress enacts a law affecting you and me, it totally forgets about separation of powers and just lumps everything under a government agency.

As you will recall, one of the major complaints the veterans made to the Subcommittee in Helena was the treatment they received at the hands of the VA. They particularly complained about the way the VA adjudicates their claims.

But the truth of the matter is that (1) the VA is only doing what Congress authorized it to do and (2) Congress is solely responsible for the fact that all the VA people involved in adjudicating a veteran's claim against the VA in fact work for, are paid by, are given promotions/transfers/pay increases/etc./etc. by the VA.

As I said at the hearing, "What the hell do you expect" when you set something up like that?

To show that Congress did not just do this with one agency (the VA), I pointed out that in the area of Social Security, Congress gave the citizen a right to file a claim. An "initial determination" is made by the SSA. If the citizen disagrees, he can ask for a "reconsideration." Who makes the reconsideration determination? The SSA.

If the citizen is still dissatisfied - (and believe me, he/she generally is!) - he/she can ask for a hearing before an ALJ. Who is the ALJ's employer? The SSA. If not satisfied with the ALJ's decision, the citizen can go to the OHA Appeals Council.

For whom do the members of the Appeals Council work? The SSA. (For all intents and purposes, the Commissioner of the SSA appoints the head of the OHA. The head of the OHA is the Chairman of the OHA Appeals Council. For all intents and purposes, the head of the OHA designates the Members of the Appeals Council of the OHA.

The members of the Appeals Council, as is true of the ALJ's and all other Social Security employees, are totally dependent on the SSA for pay raises, promotions, vacations, transfers, etc. But this is what the Congress of the United States calls a "fair," "impartial," "objective," etc., etc., procedure for you and me.

In fact, [illegible] about the same as suing your spouse for divorce and then having to let your spouse's attorney act as the "judge" in the case!

It is only after you are through with the OHA Appeals Council that you can go into Federal District Court. This will be your first real chance of getting an objective, fair, impartial, etc., hearing and decision such as the Constitution envisions.

When you get into Federal Court, what can happen? If the Federal Judge decides you were not given a fair hearing by SSA, or that there are questions of law, fact, etc., that were not fully or otherwise handled, he can "remand" the case to the OHA, the SSA and the DHHS and tell them what he wants done.

Is that good for you or me, the citizens making a claim? Let me answer this way: it is such good protection for you and me that a bill (HR 6181) now pending in the U.S. House of Representatives contains a proposal (which may now be out) that the Courts could not remand a case to the OHA/SSA/DDHS. Now who do you suppose wanted to see that happen and why?

Does that sound to you like Congress is worried about you and me? Hell, no!

Congress is not worried about us, justice, fair play, etc. It is only worried about "budgets" and protecting the rights of the bureaucracy to put the screws to us. That's why Congress is constantly strengthening the hand of the bureaucracy.

Is Congress going to make changes in the bureaucracy (like the SSA) to help us, the citizens? No. What generally happens is this: Congress sets up an agency. The public (or, the agency) wants changes made. Result: Congress goes to the management of the very agency where the problem exists and asks them what is wrong and how to correct it.

How can you possibly imagine the bureaucratic management that is responsible for the problem in the first place recommending anything that would make it easier for the citizen, or that would correct the problem, make the problem less complicated, etc.?

Here's a good example: The Social Security program is supposed to be set up so that a person who is not an attorney can represent himself/herself. (Nothing in the Social Security Act makes it mandatory that a claimant have an attorney or representative. This is true even though the claimant is severely retarded, disabled by virtue of a pschiatric disability, etc.) HR 6181 has a provision that says:

"Any initial decision the Secretary [of the DHHS] renders with respect to an individual's rights for a payment under this title. . .and which is in whole or in part unfavorable to such individual shall contain a statement of the case, in understandable language, setting forth a discussion of the evidence, the Secretary's decision, and the reason or reasons upon which the decision is based. Upon request by any such individual. . .who makes a showing in writing that his or her rights may be prejudiced by such a decision, he or she shall be entitled to reconsideration of such decision under this subsection. . ." [HR 6181, Report No. 97-588, p. 15, also see pp. 19, 24-25]

First. I know competent lawyers who could not do that.

Second. Social Security deals mainly with claims by the aged, blind and disabled. Can you see a claimant with a real psychiatric problem reading the Social Security Act and then setting down, in writing, how he/she was prejudiced under the Act by the denial?

Is the answer to require people to get attorneys and to make the whole thing an adversary proceeding? It appears that way.

Third. Last, but certainly not least, the real "kicker" here is this: just who do you think is going to read your statement as to how you may have be prejudiced under the Act by the initial denial and decide whether you are right about being prejudiced by the SSA's initial denial of your claim?

Absolutely correct: more employees of that very same li'l ole SSA that initially denied your claim.

Now, just what do you think your chances will be of getting these li'l ole SSA employees to say, "Yes, sir, you're right. We (or our brother employees) here at the SSA 'prejudiced' your rights when we/they denied you benefits.

Are you surprised to hear that, at the present time, if you request reconsideration, the figures show that in about 87% of the cases, the initial decision is reaffirmed? (See CCH, Unemployment Ins. Rpts., No. 1096, 7/9/82, p. 3)

Now stop a minute and think: We are told that lawyers, above all people, know that conflicts of interest are unethical, illegal, and all that sort of thing. We are told that, when you look at the occupations of most members of Congress, the major occupation is that of lawyer.

Do you honestly believe that lawyers in Congress look at HR 6181 and do not know that letting employees of the SSA rule on whether you were "prejudiced", (or, the proposal to take away the right of federal courts to remand Social Security cases), etc., reeks with conflicts of interest, violates the separation of powers, doctrine, etc.?

As to all bureaucratic agencies such as the VA, Social Security, etc., the Congress has been, and is, bending over backward to rule out and nullify Constitutional and other safeguards such as the doctrine of separation of powers.

In its place, Congress permits the management of bureaucratic agencies to act as the (1) legislature (enact its own rules, regulations, etc.), (2) executive (carry out the law any way it sees fit) and (3) judiciary (have "its" own in-house "judges," "attorneys," Appeals Council, act as both judge and jury with respect to its rules, regulations, decisions, conduct, etc.).

Having seen just a few examples of what Congress has given, and wants to give, us peasants in terms of law and justice, let's look at what Congress does for itself when it comes to separation of powers and all that type of thing. You don't have to look any further than Watergate and Abscam.

As you will recall, some of the greatest "law and order" men that this country has ever "heard" were involved in Watergate, e.g. Nixon, Mitchell, Ehrlichman, Haldemann, etc. Before Watergate, they had no use for the Constitution, or for any person that relied on its protections.

Any American who used the Fifth Amendment was obviously hiding something. Any American that would not permit an illegal search in violation of the Fourth Amendment was obviously some kind of criminal, communist, or what have you.

But the minute these great law and order men were caught, they demanded each, every, all, singular and sundry rights, benefits, etc., provided by the Constitution.

Each and every one wanted his own attorney (or attorneys). Each and every one wanted his case heard under the separation of powers concept - by fair, impartial, objective, etc., judge.

Not a damned one wanted his case heard or tried by some "in house" judge. Not a single, solitary one of those crooks/burglars/etc. in Watergate or Abscam wanted his case heard by some agency, such as the agency that filed the charges against him.

In short, then, when it comes to Congress, the Constitution is really important. When it comes to you or me, Congress says the Constitution is for the birds and you and are not entitled to either law or *justice*.

Third. Another item alluded to at the Subcommittee hearings was the fact that changes in the VA and other programs (e.g., Social Security) are necessary because of budgetary considerations, the current "economy," etc.

In replying to this, I pointed out that one of the things I like most about Montana is the fact that a person's "word" still counts. Maybe Montana is "behind the times" as compared to, say, California (where I practiced law for 15 years) or somewhere else because of this fact.

But be that as it may, there are many situations where a Montanan's word is still "good," without having to be in writing. Again, that is one of the things I really like and appreciate about Montana.

So as to the idea, or argument, that changes in the economy require the government to renig on its word about Social Security, VA, etc., I said - and say - "Bull!" I don't even want to hear of it.

When I was a kid - and up until recently - the United States told me that if I was a veteran and was injured in the service, they would take care of me, period. There were no ifs, ands or buts such as "providing we do not have a recession," "providing we do not have budgetary problems," etc.

Let me add that I understand that a long, long time ago, the ancient Greeks would go around their battlefields and mercifully kill their badly wounded. Some will no doubt argue that we should still do that instead of providing hospital care, veterans' benefits, etc. But the fact is that the United States decided it would not do that. Instead, as Lincoln is credited with saying, the U.S. assumed the duty of caring for him who shall have borne the battle, and his widow and his orphan.

When it comes to the U.S. reniging on its word, let's not forget Social Security. The Congress made it mandatory that you and I pay into Social Security if we worked in certain covered occupations. We had, and have, absolutely no choice in the matter.

At the same time, our government promised us that if we worked and paid into the program, we would, on reaching a certain age, becoming disabled, etc., be entitled to certain benefits. There were no ifs, ands or buts about it such as "all this depends on the state of the economy," or "depending on how many people there are paying into the program at the time," etc.

So whether we're talking about veterans' rights, Social Security or both, I don't want to hear, and refuse to accept, this garbage that the government has a right to renig because of the budget, the economy, or the this-or-the-that.

I get even madder when the President and Congress tell us this garbage and, at the same time, I see they have money for foreign aid, Congressional junkets to foreign countries, subsidies for haircuts/lunches/health care/etc. for Congress, huge write-offs for large corporations that made fortunes from the wars veterans fought, etc., etc.

While Congresses and Presidents are against providing peasants like us with any type of national (or other) health care, medical care for veterans, benefits for veterans and their dependents, Social Security claimants, etc., the same Presidents and members of Congresses vote themselves the best possible health care the country can provide, absolutely free. For sure, someone is trying to B.S. me!

Fourth: Another area I covered before the Subcommittee was a reply to a comment that was made badmouthing and "blaming" the bureaucracy. I would be the last person in the world who would defend the bureaucracy. But you show me a member of Congress who blames the bureaucracy and I'll show you someone who knows nothing about the facts of life of government in the United States.

Members of Congress particularly like to try to make us forget the fact - and it is a fact! - that the bureaucracy can only do what Congress permits it to do. For example, Congress enacts a law and the law authorizes the bureaucracy to carry it out, to enact rules and regulations.

When Congress yells about the bureaucracy enacting too many regulations, it's really just blowing smoke.

(1) The bureaucracy cannot enact even one rule or regulation unless Congress authorizes it to do so and (2) if the Congress is mad about any agency enacting rules/regs, all Congress has to do is take away the authority of the agency to enact rules/regulations.

Presto!! No problem. Also remember that the Congress - not the bureaucracy - controls the budget: Congress can whip the bureaucracy into line any time it wants by simply tightening up on the budget.

If the Congress is too weak, incompetent, impotent, etc., to fight the bureaucracy - and it is - then it has only itself to blame.

And let's face it, bureaucratic management has been outsmarting and out-everything the Congress for so long that it is pathetic.

In short, then, any time the Congress starts mouthing off about the big, bad bureaucracy, just remember that you are probably listening to someone who is running with his/her tail tucked between their legs because they don't have the courage or brains to stop the bureaucracy they created! ("Better to remain silent and be thought a fool than to speak out and remove all doubt." Abraham Lincoln)

The Subcommittee's hearings were certainly stormy. As developments after the hearings have shown, they were certainly productive. Congressman Pat Williams is certainly to be complimented for his part in arranging the hearings, participating in them and for his concern and consideration for veterans and their wives and families

Sincerely,
Don Edgar Burris

COMMITTEE ON SOCIAL SECURITY DISABILITY STANDARDS WITH JUSTICE
c/o Public Employees Federation Division No. 192
P. O. Box 395 Brooklyn, N. Y. 11201

August 23, 1982

Robert S. Lighthizer, Esq.
Chief Counsel
Senate Committee on Finance
Room 2227
Dirksen Senate Office Bldg.
Washington, D. C. 20510

Reference: Oversight Hearing on Social
Security Disability Insurance
Program - August 18, 1982

Dear Mr. Lighthizer:

Enclosed please find five copies of a statement of the views of the Committee on Social Security Disability Standards with Justice on the subject of the Disability Insurance program. We respectfully request that our statement be included in the official record of the hearing.

Our organization consists of staff members of the New York Office of Disability Determinations who are intimately involved in the administration of the Social Security Disability Insurance program.

The enclosed statement was originally prepared in connection with the appearance of our representatives before the May 21, 1982, hearing on disability of the House Select Committee on Aging. We wish to call your attention specifically to our recommendations for improvements in the disability program on pages 15-17 of our enclosed statement.

Very truly yours,

Marjory H. Odessky

Marjory H. Odessky,
Co-Chair, Committee on Social
Security Disability Standards
With Justice

Enclosures

May 18, 1982

Mr. Chairman, Committee Members, we wish to thank you for the opportunity to express our views concerning the day to day operation of the Disability Program and the effects of the many changes that have been made in it, especially in the last three to four years.

The testimony offerred by us today, represents the opinion of a great majority of our fellow professional staff members at the New York State Office of Disability Determinations. ~~We bring with us a petition signed by many hundreds of our co-workers attesting to their great concern over the many problems of the Disability Program.~~ We also think that what we have to say represents the opinions of other disability examiners in other states across the country.

Mr. Chairman, we would like to begin our testimony by drawing two profiles - one of a disability recipient whose benefits have been ceased under the ACDI program and the other a disability claimant whose recent claim has been denied. Neither one of these people actually exist. However, they are accurate representations of actual recipients and claimants.

The first person is Mary Smith. Ms. Smith was put on disability soon after the inception of SSI, in 1974. She suffers from a variety of impairments that have prevented her from working since 1965.

However, it was not until 1974, when the government began to publicize the availability of disability payments under the SSI Program, that she realized her eligibility under Title II. She applied for Title II benefits and was found, under the standards and practices that existed at that time, to be so severely impaired that she was declared disabled. Subsequently, due to changes in her financial situation, she also became eligible for SSI. Because her impairments were of a static nature, it was decided that her case would never have to be reviewed. She had been receiving her monthly checks until 1981 when our State agency, under Congressional and Social Security Administration mandates, reviewed her claim and solely because of the changes in the laws and regulations which have occurred since 1974, ceased her benefits. (Under the provisions of the 1980 amendments, she would not have been reviewed until 1982, but SSA began their reviews in 1981.) Ms. Smith then became a woman without any financial support. With no work history since 1965, no recent vocational skills to rely on, and a history of severe medical problems, Ms. Smith must now go out and find a job or re-apply for welfare.

Our second profile concerns Howard Jones. Mr. Jones is 55 years old. He has a work history as a butcher. His job involved a good deal of heavy lifting. He had been at that job for 19 years.

Mr. Jones has a severe cardiac impairment which has necessitated coronary artery bypass surgery because of severe chest pains brought on by occluded coronary arteries. After the surgery, Mr. Jones experienced the return of his chest pain. Since his doctors performed a variety of post-bypass tests, the results were obtained and when interpreted in the light of SSA's medical/vocational standards, it was decided that Mr. Jones has a residual functional capacity (RFC) for light work. Since Mr. Jones' prior work was medium work, he can no longer return to it. However, since it was also highly skilled work, we are mandated to say that he has skills transferable to jobs within his RFC. According to the ways that SSA tells us to make these decisions, Mr. Jones is able to do other work and is not disabled.

These two profiles represent, in capsule form, some of the enormous problems, inequities and injustices of the Disability Program. The members of Congress, here in Washington, and the Social Security Administration headquartered in Baltimore have created a program that contains minimal opportunities for compassion and understanding and, at the same time, fails to deal with real human problems in any real way.

However, the day to day burden of administering the program falls on our shoulders. We are the ones who are actually forced to deny benefits to our fellow human beings. We are the ones who receive the Congressional inquiries, the irate phone calls from your constituents, the suicide threats, or news that a claimant whose benefits we were forced to cease, actually pulled the trigger or jumped out the window.

Mr. Chairman, it takes its toll. Our fellow workers are not the heartless people that claimants think we are. Most of us are concerned and acutely distressed that we are forced to work in a system that is supposed to provide protection for our fellow citizens, but instead, because of its' severe standards and rigid rules, leaves little room for compassion and sensitivity.

We did not create this system. It was created here by your colleagues and in Baltimore by the administrators of the Social Security system some of whom, apparently, seem quite satisfied by the program's recent trends. It seems to us that the problems of the systems were created by some who are too high up and removed from the ordinary citizen that this program was intended to serve. The further removed from the people the program becomes, the more the program takes on a bureacratic logic all of its own. As a consequence, the needs of your constituents are not served.

It is abundantly clear that since the late 1970's, Congress and SSA have consistently legislated and administered the program in a way that has resulted in more and more applicants and recipients with increasingly severe levels of impairments having their claims denied or benefits ceased. This is the result both of express law and regulation as well as clarifications and directives contained in national and regional circulars, which affect the adjudicative climate of the program.

The medical standards of the program are so severe as to be a detriment to the health and welfare of millions of Americans. Many of these people have worked hard for 20 - 30 years or are living at or below the poverty line. They suffer from severe forms of illness and/or injury and cannot benefit from the Disability Program because of overly stringent standards that bear only a tenuous relation to the real world where real people suffer from real impairments.

The situation changed considerably in 1979 when new medical standards went into effect. In some cases, the medical listings were drastically altered. This was especially so for musculoskeletal, cardiac and neurological impairments. Some other types of impairments underwent similar changes. Others remained as they were. However, the three types of impairments mentioned along with mental disorders, are the "Big Four" impairments and constitute the overwhelming number of cases that disability analysts handle.

Any increase in the severity of these standards will have an effect on how many claims are allowed and increase the number of denials.

The easiest medical listing with which to illustrate this increase in severity is the neurological listing. Under the older standards, one of the key things that was looked for was whether a person had a "...moderate motor deficit in two extremities". The newer and current standard says something quite different. We must now look for "...significant and persistent disorganization of motor function in two extremities, resulting in sustained disturbance of gross and dextrous movements, or gaits and station".

The difference between the two is obvious. The older standard refers to moderate loss of function due to a CVA, cerebral palsy, multiple sclerosis, brain tumors and the like. The newer standards require the near uselessness of two extremities. To us, a more humane view is that a person becomes disabled long before his or her limbs have reached the point of effective uselessness.

The changes in the medical listings were supposedly made for two purposes. One purpose was to recognize and take into account advances in the medical profession. The other was to provide clarification and needed definition as to the type of medical documentation needed to properly adjudicate a claim.

However, a medical advance that either makes life possible or more comfortable should not militate against a finding of disability. A person who has had his or her life spared by a new medical technique may still be quite disabled.

In addition, each clarification and definition, in fact, represents another piece of medical documentation needed to make an allowance that was not needed before. Each piece of additional documentation represents a level of severity to be reached that need not have been reached before. This inevitably leads to more denials.

In addition, SSA puts greater and greater pressure on the analyst to obtain more and more objective, as opposed to subjective, medical documentation in order for a claim to be properly adjudicated. In one sense, this is sound practice. We cannot make an allowance based on allegations and subjective complaints alone. There must be other corroborating medical data.

However, SSA takes it's emphasis on objective data to extremes. In it's over-emphasis on objective results, SSA overlooks the way medicine is practiced in the real world. A physician does not evaluate a patient solely on the basis of test results.

Physicians also must take into account subjective factors such as pain, pain threshholds, range of motion, psychological stress of illness or injury and the like. Objective factors, combined with subjective factors lead the doctor to form an overall judgement as to how impaired the patient is.

In the Disability Program, there is a systematic effort to de-emphasize the subjective and, in addition, to assign specific residual functional capacities to specific objective findings. The assertion that this test result revealing that severe condition specifically equals that functional capacity, defies all reality, logic and medical sense. In addition, it robs the disability analyst and review physicians of the opportunity to exercise judgement and compassion in the claimant's behalf. Therefore, there is a definite difference between making "correct" decisions according to the regulations and guidelines which is what analysts are judged by and humane disability decisions which all too often we cannot make.

We are told to use these artificial RFC's in combination with the claimant's vocational history to make a large number of our disability decisions. Using these vocational histories and artificial RFC's, we often have to decide if a claimant is too impaired to carry on in his former line of work or whether he or she has skills transferable to other jobs.

If the claimant does, then we are required to deny the claim. Another way of putting it is that we explicitly say to the claimant that we understand that you have a severe impairment that prevents you from doing your usual work. However, there are other jobs that exist elsewhere in the national economy that you can do.

It seems not to matter that a person may be 50 years old or older and may have worked at a single job for 15, 20, 25 years or longer. Nor does it seem to matter in reality that few employers readily hire older workers, let alone those with impairments so severe that they are prevented from continuing in that line of work. So, in effect, disability analysts implicitly say to claimants, "I'm sorry you can't do your former work. Here are a list of jobs which you can perform instead, which you will probably never be able to find". Such actions and decisions lead to nothing but cynicism on the part of the public and constitutes a breach of faith that the American people put in their government and Social Security system.

Disability analysts, besides being responsible for the quality of their decisions, are also under pressure to produce a decision in the least amount of time possible. We must constantly juggle the need for proper documentation with this time pressure. Often this forces us to send claimants to one of our doctors for a consultative examination to complete proper documentation in a timely manner.

The consultative examination forces disability analysts to consider other dilemmas in the disability process. One is that these exams are often done by high volume providers. In our opinion, the quality of these exams and resultant reports is sometimes suspect. But without definite proof to the contrary, these reports must stand in the record as proof of what the claimant's condition is.

Nevertheless, even if these exams and reports were reliable as they should be, the examiner must consider a second dilemma--what to do if there is a conflict between the medical evidence from the claimant's doctor and our consulting doctor. In our system, primary emphasis is given to reports from consultative examinations over treating source reports. In our bureaucratic way of thinking, the explanation is that sometimes a treating source will sometimes slant a report to help his patient, while a consulting physician will be neutral and therefore, 'more objective'.

While this may be true in some instances, this also shows how far from the real world this program can be. In the real world, patients see their doctors when they are feeling ill and their symptoms are at their worst. They go to see our doctors when they are told to go.

This may not necessarily coincide with a period of greatest symptomotology. The resultant medical report will make the claimant appear more functionally able than he or she really is and lead to a greater amount of denials.

All of these problems in the day-to-day work of the disability analyst are magnified by additional problems superimposed on the program by the 1980 Amendments to the Social Security Act. We speak of the ACDI program.

Beginning in 1980, SSA began to study cost effective ways of cutting the disability rolls. It began a pilot project known as the CDI Redesign Study to see what would happen if Disability recipient's folders, which were never supposed to be re-examined, were sent back to the state agencies for medical re-examination.

It was found that a relatively high percentage of continuing recipients could have their benefits ceased at great savings to the Disability Trust Fund. As a result, Congress passed the 1980 Amendments which provided for periodic review of claims.

It is true that in periods up to the late 1970's, some people were put on disability who should not have been. Others have, for one reason or another, recovered from their impairments to a sufficient degree so that they, too, should no longer be considered disabled. Therefore, we support the general concept of periodic review as a means of insuring that those receiving disability remain disabled.

However, we do not believe that periodic review is being administered in the best interest of your constituents. In fact, it has wreaked great havoc in the lives of many thousands of people and threatens many thousands more. People have even committed suicide because their benefits were cut off and they were told that they were no longer considered disabled.

Under the current ACDI program, cases are being selected for shipment to the various state agencies on the basis of type of impairment, age of the recipient, and/or on the amount of monthly benefits that the recipient and his family are entitled to. In New York State, the cessation rate is approximately 50%.

All of these people were judged, under the less severe medical standards and adjudicative climate that existed in the past, to be so impaired that they would never improve and would never be able to work. They were put on disability and were told that their medical conditions would never have to be re-examined. In effect, they were promised 'permanent' disability.

Now, folders by the thousands are being sent back for re-examination in the light of more recent and severe standards and climate. This has already resulted in claimants, whose conditions have shown no significant improvement, having their benefits ceased. Thousands more just like them will face benefit termination in the future.

This means that the government's word has become valueless. If promises, either implicit or explicit, can be broken in this manner, what is to prevent the government from breaking promises to any other class of recipients past, present or future?

Also, the widespread dislocations that are and will be caused by the cessation of benefits have been effectively overlooked by Congress and SSA. As a result, many people who have been on disability and out of the work force for many years have obsolete or non-existent vocational skills. Without extremely effective vocational rehabilitation programs which, so far, do not exist, these people are and will be cut off from disability income and left to fend for themselves. In other cases, we have ceased older claimants because they are supposedly able to work. They were then referred to OVR only to be told that they were too old to make a successful vocational adjustment.

Psychiatric claimants have had an especially difficult time because of ACDI. Although the medical standards for psychiatric impairments have remained relatively stable, the adjudicative climate has changed drastically in the last few years. It often seems to us that, in order for a psychiatric claimant to have his claim allowed or continued, he must have lost, because of his psychiatric impairment, every last quality that makes a human being.

Fortunately for psychiatric beneficiaries in our state, the climate for adjudicating their CDI claims has improved considerably in the last few months through the efforts of forceful advocates such as New York City Council President, Carol Bellamy.

However, the climate for initial psychiatric claims remains unchanged.

This raises the question of who advocates for the mentally ill in other states? Who raises a voice for the neurologically or the orthopedically impaired or those with cardiac impairments or with cancer? Who will protect their benefits or help them gain access to the system?

Before we turn to our recommendations, we would like to leave you with two true stories which we have knowledge of. One concerns a man with musculoskeletal and cardiac impairments. His claim was allowed and benefits were started.

His case was returned from the Office of Disability Operations in Baltimore for re-adjudication of what they saw as an erroneous allowance. His case was re-adjudicated and with additional evidence the original decision was affirmed, and the claim was returned to Baltimore. Office of Disability Operations returned it a second time because they insisted that the claim should be denied. The claimant checked with this office concerning his reconsideration rights, he killed himself a week later. We learned about this when the regional office, a part of SSA, called to find out what had occurred on the case.

The other story was printed in the New York Post on May 14, 1982. It concerned a man with a cardiac impairment. On the initial level, his claim was denied because he was supposed to have the capacity to perform other than his past work. The claimant filed a request for recondersideration. He died from his impairment while a decision was still pending.

Mr. Chairman, we would like to close by recommending that changes be made in the Disability Program in the following manner:

(1) The overall adjudicative climate should be altered so that we are allowed some discretion in making disability decisions that reflect a little human compassion and enable us to give the little man the benefit of the doubt in a big system.

(2) Some relaxation of documentation requirements so that we no longer have to prove that someone is disabled 'beyond a reasonable doubt'.

(3) Place greater emphasis on reports from treating doctors except where there is some reason to believe that the report may not be valid.

(4) Appointment of an independent board of medical experts for the purpose of re-writing the current medical listings.

(5) A complete re-working of the way in which we assess residual functional capacity that is more reflective of the way real impairments affect real people.

(6) Some alteration of the current medical/vocational rules-specifically, elimination of some of the inequities created by vocational rules 201.00, 202.00 and 203.00; also require that if a worker, aged 55 or older, is judged not capable of performing his past work, he or she should be judged disabled.

(7) Require that SSA use greater judgement in selecting cases for ACDI review. Specifically cases should be sent back for review solely on a medical basis. Even on a medical basis, cases should not be reviewed if:

(a) Claimant is 59 years of age or over.

(b) Claimant has been out of work force due to a disability for more than fifteen years.

(8) Require that if a recipient's claim is being reviewed because of the ACDI program and the person's condition has shown no significant improvement, that benefits be continued regardless of current medical standards.

(9) If a claimant is ceased because of ACDI then the benefit grace period should be proportional to the amount of time that the person has been out of work force, up to a maximum of 12 months worth of benefits.

(10) Allow Title II recipients to continue to receive benefits while the appeals process runs its' course as is the case with Title XVI recipients. Also, if the claimant loses his appeals, benefits should be ceased without any retroactivity, except in clear cases of fraud.

(11) Create expanded, effective and accessible vocational rehabilitation that will realistically retrain people for re-entry into the job market. It is a disgrace to cease benefits to people who have not worked in many years and whose vocational skills are now obsolete. We cannot leave these people out in the cold.

Testimony of the Honorable Robert W. Edgar, M.C. before the Senate Finance Committee

August 18, 1982

DISABILITY INSURANCE PROBLEMS: CONTINUING DISABILITY REVIEWS

Mr. Chairman and Members of the Subcommittee, I appreciate the opportunity to appear before you today to speak about Disability Insurance. As you know, my colleagues in the House have been working hard this session to address many of the questions your subcommittee will be studying. One product of these efforts, the Disability Amendments of 1982, is pending on the House calendar. Numerous additional initiatives are in the pipeline in the House of Representatives, and in this house my fellow Pennsylvanian Senator Heinz has introduced a similar package of reforms.

Mr. Chairman, this plethora of legislation is not a result of showboating, but of grave concern on the part of many Members in both Houses regarding the status of the Disability Insurance program of the Social Security System. In 1980 the Congress wisely chose to review disabled individuals to insure that they still qualified for benefits. Legislation to accomplish this task was introduced after publication of a Social Security Administration study which estimated that as many as 20 percent of the persons on the disability roles who were not periodically reexamined no longer met the disability criteria. These instances cost the disability insurance trust fund as much as $2 billion per year. Thus, Section 311 of PL 96-265, the Disability Amendments of 1980, mandated that the Social Security Administration review the status of disabled beneficiaries every three years if they are not classified as permanently disabled.

Although the new law provided for these continuing disability investigations to begin in January, 1982, the new Administration chose to start the process in March, 1981. By January of this year, there was great enough concern on the part of Members that the General Accounting Office was asked to study the medical status of the large numbers of beneficiaries being terminated from the rolls as part of these accelerated reviews.

Mr. Chairman, the problem with the accelerated disability investigation process lies not in the philosophy behind it, with the idea of assuring that all disability insurance recipients are actually disabled, but with the manner in which the investigations have been carried out. The Social Security Administration's original estimate of 20 percent ineligible recipients has translated in practice to a termination rate of 45 percent. Eighty to 85 percent of thse recipeints are appealing their cases to the administrative law judge level, and 65 percent of these appeals are successful. This high rate of overturned decisions indicates that a substantial problem exists with the reviews.

This statistical approach to the problem is very antiseptic. Let me illustrate my point more vividly by describing some specific examples which my caseworkers in Delaware County, Pennsylvania, have brought to my attention:

---One of my constituents, who had been receiving benefits since 1972, was reevaluated in the early part of this year. He had multiple problems: an accident in 1970 had left him with spinal injuries, and he underwent several back operations. Originally he suffered from severe back pain and muscle spasms, and doctors judged him unfit to perform substantial gainful activity. Over time, his condition became worse as the pain and spasms moved to his neck. Doctors feel that the problem might be solved by further surgery, but the chance of success would be only 25 percent, with a 25 percent chance of total paralysis and a 50 percent chance of death. Nevertheless, in February his benefits were terminated. On February 16 he appealed to the state reconsideration level; only last month was the state decision reversed on the record by an administrative law judge. The extended period without benefits and his anxiety over his case have caused such mental distress that he has almost been forced to seek psychiatric care.

---Another man who lives in my district has been receiving disability insurance for several years, a result of various psychiatric problems. Last year his case was reviewed and his benefits were cut off. An administrative law judge

> reinstated his benefits, but the stress of the cessation and subsequent procedures and uncertainty aggravated his condition. His physician is of the opinion that his condition deteriorated significantly as a result of the process. This year he was terminated again, and presently has an administrative law judge hearing pending. It seems likely, according to my caseworker, that he will have his benefits reinstated.

Mr. Chairman, in order to properly attack this problem and to introduce an element of compassion into the continuing disability investigation process, I would ask that you and your committee strongly consider taking some of the steps I am about to propose.

There are three areas in which we must finetune the 1980 disability provisions and alter the existing statute governing the continuing disability investigations. First, we must act to smooth the passage back to work for those who are terminated from disability insurance. There are several ways in which to do this. One is to provide additional adjustment benefits for those who are terminated, allowing them to change their personal and financial arrangements to cope with the new situation. If such an additional benefit was offered to those who received disability benefits for at least 36 consecutive months before termination, it would relieve some of the anxiety that these beneficiaries feel when their benefits are terminated after many years. Next, the month when termination becomes effective should be the same month in which the termination notice is received by the beneficiary. This provision would protect those whose recovery is judged to have occured before they were reviewed. Once the initial round of continuing disability investigations is performed (by 1984), such retroactive terminations should not be a problem. Finally, funds should be earmarked for rehabilitative services for persons terminated in the next two years, recipients who have been on the rolls for a number of years and were suddenly dropped.

The second area in which we must contemplate changes is in the review process itself. One of the most important steps, never taken by the Social Security Administration, is to notify all disability insurance recipients of the review process and explain it to them. Even this simple action would increase understanding and reduce stress on the part of many disability recipients. Considering the large number of terminations upheld at the state reconsideration level and the almost equally large percentage of terminations overturned at the administrative law judge level, it is imperative that benefit payments be continued through this latter stage of the review. As I mentioned earlier, 80 to 85 percent of those terminated choose to appeal their decisions, and 65 percent of these are successful in their appeals. For these recipients to be left without benefits during the appeal process is not only unfair, but can cause incredible hardship for a recipient and his or her family. Those who lose their appeals should certainly be required to return any benefits received in the interim.

In order to strengthen the review process, we must give the states a better perspective on the cases they are reviewing. One method for accomplishing this is to provide for face-to-face interviews at the state reconsideration level. Under the present system, the recipient does not appear personally until the ministrative law judge stage. Allowing face-to-face visits at the reconsideration stage should work to make that process more than a mere cursory review of the original state examination and to take pressure off the ALJs. Lastly, attempts to close the record before the ALJ level must be resisted. Although maintaining an open record to this stage may allow for some reversals, it provides a type of insurance for the many recipients who do not secure counsel until the ALJ stage or are otherwise at a loss when confronted by a confusing quasi-judiciary process.

The third area in which we might move to reform the existing statute is in the rules for the reviews. One of the major reasons for the astounding reversal rate of state termination decisions by ALJs is that the two levels use different sets of regulations to guide their decisions. The states use the Program Operations Manual System for making their judgements, while the ALJs have much wider latitude: they use their individual interpretations of the statutes, applicable regulations, and Social Security rulings. We must move to rationalize the process by which decisions are made. However, the Social Security Administration's attempts to bring ALJs under the Program Operations Manual System-type guidelines called the Social Security Rulings is fraught with danger. I believe that we must bring the varying rules more in line with each other, but it is couterproductive to make all of the guidelines pertaining to continuing disability investigations internal and unpublished. If we are to restore public confidence in the review process we should have the the Social Security Administration publish any rules for continuing disability investigations in the Federal Register so that they will be subject to public comment before implementation. Only in this way can we standardize the termination guidelines and concurrently make the review process more open and compassionate.

The other major modification necessary in these continuing disability investigations is to establish a fair and equitable benchmark for terminating persons receiving disability insurance benefits. One of the principal complaints, indeed, the principal complaint about the current round of accelerated reviews is that they have removed people from the roles who have experienced no change in their physical condition. Some who have been terminated have actually experienced a deterioration in their physical or mental health. Mr. Chairman and Members of the committee, I do not dissent from our 1980 decision to tighten the eligibility requirements for disability insurance. However, I strongly feel that we cannot apply new, more stringent standards to persons who have experienced no improvement in their condition. I would be the first to advocate the return to work of those whose medical condition improves and who no longer fit the definition of disability. But it is improper to grandfather recipients, to remove them from the roles after years when they have been assured that they are disabled and unfit for work. We must apply new guidelines to new applicants.

Finally, we should encourage terminated persons to attempt a return to work before pursuing an appeal of their cutoff. One way to do this is to extend the time limit for filing an appeal of their cutoff. One way to do this is to extend the time limit for filing an appeal for a state reconsideration from 60 days to 180 days. This change would allow a terminated recipient six months to find a job and attempt to reenter the work force, rather than forcing him to appeal almost immediately for fear of inability to maintain a job. Failure to keep a job because of medical disability would also provide more compelling evidence at the reconsideration level.

Mr. Chairman, both houses of Congress recognize the necessity of the continuing disability investigations. At the same time, every one of us has heard of the agony and trauma suffered by those unjustly dropped from the disability insurance rolls as the reviews continue. In order to give us time to consider modifications to the continuing disability investigation process, and in order to add some time for reflection on the effects of the program to date, I have introduced a companion bill in the House to Senator Heinz's S. 2730. This legislation will provide for a moratorium on continuing disability investigations until January 1, 1983, giving us all time to review the process and modify it. Of course, all cases of medical diaried reviews would be exempted, as would those involving fraud and abuse of the system. This is only a short break, but one that would allow us to contemplate the result of our legislation without seriously disrupting the review process. I hope that you and your committee will seriously consider some of these ideas as you examine the present disability provisions.

I would be happy to answer any questions you might have.

1.

September 1, 1982

Mr. Robert E. Lighthizer
Chief Counsel, Committee on Finance
Room 2227, Dirksen Senate Office Bldg
Washington, D.C 20510

Dear Mr. Lighthizer:

I realize the deadline for a written testimony was Sept 2, 1982, but I was not aware until today, Sept 1, 1982 that a written testimony was possible. So I ask that you please Consider this for your pending hearings.

I am on disability due to a massive heart attack, which Occured on April 7, 1981. At the advice of my physician, I applied for Social Security benefits in May, 1981. After the normal waiting period, I received my first monthly benefit in November 1981.

On June 18, 1982, I recived a notice from the Roanoke, Va. office that my case was under review. Enclosed with the letter were several pages of questionaires and three medical release forms. I answered the questionaire and do not feel the determination specialists are qualified and familar with different types of occupations to make a fair and just decision. On the work history report that I completed, asking for the last fifteen years of work I had performed, I gave a complete run down of all positions held with my employer at the time of my disability. I gave a full description, including sitting time, standing time and walking time. Also, the lifting involved in each job. My previous job with another employer was a furniture upholsterer. I did not give details or the requirements of this job. As anyone would know, the weight and physical strain on lifting couches and chairs is completely out of the question for a person with severe heart damage. This was the job recommended by the disability determination specialist in her letter of August 2, 1982 if I could not provide further evidence that I was still disabled. She also stated that I could lift up to fifty pounds and walk six out of eight hours. I feel she chose this job because it was the only one I neglected to describe. She completely ignored the medical evidence and physicians opinion, submitted in July, in determing my case.

My physician wrote _another_ letter on August 9, 1982. We submitted this as additional evidence. As of this date, we like many others, are awaiting the final blow, which has already been determined, I'm sure.

I do not disagree with the investigation of the disability recepiant. I feel this is necessary. I do disagree with the manner in which it is done. I do not feel the disability specialist should have the authority to overrule my Dr.'s professional opinion when he submitted medical evidence to substantuate my physical disability.

I feel the determinations are being made unfairly and inaccurate. I also feel the benefits should continue through the appeal stage, or ruled on by an administrative law judge.

Thank you for your time and any considerations.

Fletcher J. Rice
Route 4 Box 372
Salem, Va 24153

Phone 1-703 384-6207

INTERNATIONAL
REHABILITATION
ASSOCIATES INC.

985 OLD EAGLE SCHOOL RD
WAYNE, PA 19087
(215) 687-9450

September 22, 1982

Robert E. Lighthizer, Esquire
Chief Counsel, Committee on Finance
2227 Dirksen Senate Office Building
Washington, D.C. 20510

Dear Mr. Lighthizer:

International Rehabilitation Associates, Inc. (IRA) has followed with great interest Congressional activity involving the Social Security Disability adjudicatory system. We have communicated with the House Committee on Ways and Means with reference to HR 6181. We have proposed an approach that we believe, based on our own private sector business experience, would permit a prompter and more accurate disability determination process. We have suggested that this approach be tested on a demonstration basis to determine its applicability in the public sector.

IRA is the oldest and largest independent provider of insurance rehabilitation in the world. We are a wholly owned subsidiary of the CIGNA Corporation. Our home office is in Wayne, Pennsylvania. We have 84 other offices across the country as well as in Canada and Australia. Since 1970, we have served approximately 130,000 handicapped citizens. I am appending information which tells more about IRA.

An Analysis of the Current Disability Determination System

IRA believes the Social Security Disability Insurance System generally is working but that the system can and should be tightened. The goal should be to assure that every individual who is legally disabled receive benefits and that no one who is not legally disabled receive Social Security Disability benefits. Further, it is our feeling that those individuals who can benefit from rehabilitation services, either to reduce long term medical costs or to return to work, should receive those services. It is in everyone's interest that the determination of disability be made fairly, promptly and with adequate protection of due process. And the determination process must be cost-effective.

Recent studies by the Bellmon Commission and by the General Accounting Office, as well as thousands of letters to Congress, attest to the fact that the current system does not succeed in achieving all of these goals. In 1980, there were approximately one million claims including Social Security Disability Income (SSDI), Supplemental Security Income (SSI), and concurrent claims. Of these claims, 670,000 individuals were denied at the initial claim level. Of those denials, 295,000 individuals requested reconsideration. Only 15 percent (or 45,000) of those requesting reconsideration were allowed at that level. Yet when 163,000 of those claimants denied a second time requested a hearing, almost 60 percent (or 96,000) of their claims were awarded at the final stage. Even those statistics may not reflect the full problem. Some of the claimants denied benefits at either of the first two levels may have ceased efforts in discouragement rather than because they believed they were not deserving of benefits.

These statistics reflect at least two problems. The first problem has been discussed recently by the General Accounting Office (GAO) and summarized in the Congressional Record of July 15, 1982. The respective State Disability Determination Units (DDU) use a very specific set of guidelines called the Program Operating Manual System (POMS) for the initial and reconsideration decisions. The Office of Hearings and Appeals (OHA) uses a different set of guidelines at the appeals level. Hence, different decisions on a given case may be based on the use of different guidelines.

The second problem has been discussed both in the Bellmon report and by the General Accounting Office. File development of disability claims is often inadequate up to the appeals level. The applicant for benefits often has little idea of what information is needed to support a claim. Frequently physicians are equally naive and submit inadequate medical information. Very often no one gathers sufficient vocational information. This is particularly surprising in that the Social Security definition of disability is so closely married to vocational issues. And it was the GAO's belief that additional information did make a difference in the ultimate adjudication of a claim.

A Private Sector Approach to Disability Determination

IRA believes there are a number of ways the private rehabilitation sector could be mobilized to help solve many of the vexing problems of the Social Security Disability System. The most immediate need is in the disability determination process both for new claims and for continuation of disability benefit adjudication. Continuation of disability benefits merely represents a subset of the broader problem. Private sector organizations are now called upon to perform these functions with respect to private insurance programs. Based on our own experience, we suggest that Social Security consider experimenting with a system in which processing of claims is facilitated by a private sector organization performing functions such as those which the private insurance industry has found to be cost-effective. Any individual requesting reconsideration of a claim would receive active assistance in putting together adequate information for the claim to be fairly judged. The format of the data should be consistent and should be gathered by a rehabilitation professional trained in both medical and vocational issues impacting upon disability. This professional would meet with the claimant and with the treating physicians. When consultant examinations are required (and we believe fewer would be needed than under the present Social Security mechanisms), the rehabilitation provider would be able to help the consulting physician better understand what information is most useful in deciding the validity of the claim. The medical and vocational information so collected would be adapted into a standardized format and fed into a computer system. The computer would sort the data yielding concrete information including the applicant's skills, education, and capacities and merge this information to numerous existing data sources including labor market statistics and even specific employers. Thus, alternative physically and environmentally compatible occupations existing in the economy would be identified. This cumulative body of information would be forwarded to the state DDU which would make the determination of eligibility. This information would also provide guidance for active rehabilitation interventions.

The Congress has already authorized SSA to experiment with private sector participation in the rehabilitation process itself. IRA believes our recommended approach to disability determination should be tested and that provision for this approach should be included in pending legislation. The computer technology already exists. Moreover, the private rehabilitation sector has, for years, served an information gathering and analysis role for the insurance industry, employers, and many governmental agencies, permitting those organizations to make better decisions. In fact, the SSA's disability determination examiner is in a position directly analogous to that of the insurance claimsperson. The insurance industry has increasingly turned to private sector rehabilitation organizations to perform sensitive and thorough data gathering and wherever possible to offer rehabilitation service as well.

Summary

In brief, IRA strongly encourages Congress to recognize that the shape of rehabilitation is quite different in 1982 than it was in 1972. New computer technologies, information systems, and case management techniques that were not available a decade ago can now be used to solve old and difficult problems. We believe that the private sector has available systems which may be adaptable for public policy purposes that will permit:

- better decisions to be made earlier in the disability determination process;
- better monitoring of the condition of those individuals receiving benefits;
- better rehabilitation planning of those individuals with potential (as recommended by the GAO);
- a better feeling on the part of those citizens applying for benefits that their government has been more responsive to their needs; and
- better and more efficient use of money now being used to gather information about applicants for disability benefits.

These objectives are, in fact, being achieved now with respect to private sector disability coverage and rehabilitation programs. We believe that the private sector has a contribution to make to the more efficient operation of programs under the jurisdiction of SSA. At the same time, we recognize the prudence in proceeding carefully to experiment even with an effective private sector technique to determine its appropriateness for a large-scale public program. The technique must adhere to certain specific standards of quality, cost-effectiveness, and accountability. We stand willing and anxious to be part of the solution to these important public policy problems.

Sincerely yours,

V. Gordon Clemons
President

VGC/bh

A Brief Description of IRA Services

IRA provides rehabilitation evaluation and related services to individuals at the request of insurance companies, self insured corporations, claims consultants, administrators, and government agencies. All told, IRA serves more than 1000 such organizations. The insurance companies pay our fees. Our services are extended in connection with various kinds of insurance coverages - mostly workers' compensation, long term disability, and automobile.

Our specialists perform a wide range of services starting with medical care coordination. They meet with the client's physician. They visit the client's job site and perform a job analysis. A job analysis is an evaluation of the physical and mental requirements of a specific job. The job analysis is important because two jobs with the same job title in two different companies may differ significantly. We also provide job placement assistance.

While we do not do "hands-on" work like medical treatment, nursing, occupational therapy, physical therapy, or psychotherapy, we do try to identify the client's capacity to perform substantial gainful employment and we do try to help the client achieve those goals in the shortest possible time.

STATE OF MICHIGAN

WILLIAM G. MILLIKEN, Governor

DEPARTMENT OF MENTAL HEALTH

LEWIS CASS BUILDING
LANSING, MICHIGAN 48926
FRANK M. OCHBERG, M.D.
Director

September 7, 1982

The Honorable Robert Dole, Chairman
Senate Finance Committee
United States Senate
Washington, D. C.

Dear Senator Dole:

I am pleased to provide testimony for inclusion in the proceedings of the [redacted]gs recently held before your committee. Let me commend you and other members of the Senate Finance Committee for conducting the August 18 public hearing on a subject of significant concern to Michigan state government. This hearing was especially relevant to the directors of six state departments who have assigned staff to work collaboratively as part of an "Interdepartmental Disability Task Force." These departmental staff represent education, mental health, public health, social services, management and budget and labor, as well as advocacy groups, to monitor federal activities related to disability benefits.

Members of the Interdepartmental Disability Task Force have analyzed pertinent legislation, developed impact analyses of federal budget proposals and recommended policy positions for adoption by Michigan state government. Based on the research conducted by Task Force members, as well as my personal commitment to ensuring support for the truly disabled, I am offering the following recommendation to you and your Senate Finance Committee colleagues.

Recommendation: CONDUCT A SERIES OF OVERSIGHT HEARINGS REGARDING THE VALIDITY OF CURRENT DISABILITY CRITERIA AS A MEASURE OF NON EMPLOYABILITY

Justification: Analyses of federal data reveal that individuals whose SSDI benefits are terminated after a Continuing Disaability Investigation (CDI) rarely, if ever, affirm the non-disabled decision by achieving a level of substantial gainful activity (SGA). Following are summaries of several such studies which demonstrate that unemployaability does not always lead to receipt of benefits.

A 1976 Social Security survey[1] examined applicants who were denied benefits in 1967. The report discusses the circumstances facing these individuals in 1973, six years after their denial. The 1973 follow-up data revealed the following information regarding employability and actual earnings:

- 80% of the denied failed to engage in sustained competitive employment during the six-year period studied;
- 67.5% of the denied had earned nothing during 1973;
- 16.8% of the denied earned less than $3,600 in 1973;
- 15.7% of the denied had earned more than $3,600 in 1973.

A 1979 Social Security report[2] examined claimants who were awarded benefits by Administrative Law Judges (ALJ's), subsequent to denial by disability examiners. This report reveals actual earnings received by denied applicants during the five-year period from 1970 to 1975.

- 62.5% of those denied by the ALJ earned nothing during the subsequent five years;
- 80.5% of those denied by the ALJ earned nothing in 1975.
- 9.7% of those denied by the ALJ earned less than $4,600

in 1975.

Finally, a 1970 Social Security study[3] of persons denied benefits between 1963 and 1965 states that "in no group was there more than token full time work (p.7)." The 1970 data reveal that only 1% of the individuals studied were employed full time. Of those males who were employed, median incomes did not exceed $2,670 per year. Of those females employed, median incomes did not exceed $900 per year.

I believe these studies demonstrate the current definition of disability, as applied in practice, is a less-than-reliable indicator of unemployability. Application of the current definition deviates greatly from the intent of congress, i.e., that a safety net will be maintained for truly disabled, unemployable individuals. For this reason, the generic intent of SSI/SSDI disability benefit programs should be reviewed and reaffirmed by your Committee.

Should you initiate oversight hearings, I further recommend that the definitional changes included in President Reagan's FY 1982-83 budget be closely scrutinized. These two definitional modifications (to extend the prognosis of permanent disability from 12 to 24 months and to eliminate vocational factors when determining eligibility) would produce devastating consequences among the disabled, especially the mentally ill and developmentally disabled.

177,500 Michigan citizens currently receive SSI and SSDI benefits. A recent Michigan report[4] estimates that, should the Administration's definitional changes be enacted, the following benefit termination statistics would apply:

- Each year, 25% of current SSI/SSDI beneficiaries would be terminated.
- The number of new SSI/SSDI beneficiaries would be reduced annually by 38%.
- Michigan's termination rate would increase from 41% to 57% (between 1982 and 1984).
- Since SSI and Medicaid use the same eligibility standards, the eligibility of 22,000 Medicaid recipients who receive benefits due to disability would be jeopardized.

SSA's proposed FY 83 definitional changes would remove currently eligibile individuals from the protections of congressional intent. Therefore, your Committee should carefully contrast SSA's proposed FY 83 definitional changes with program reforms, such as those proposed by Senator Levin, Senator Riegle and Congressman Davis, all from Michigan.

Specifically, the Interdepartmental Disability Task Force supports concepts, such as the following, which would improve the correlation between non-employability and the definition applied in awarding disability benefits:

- Senator Levin's "Social Security Disability Amendments of 1982" (S.2674) would require: (1) public comment before disability standards could be modified, and that uniform standards would apply to all levels of decision making; (2) that examiners must document medical improvement, or an erroneous initial decision before benefits could be terminated; (3) that clients receive advance notice of the intent to terminate benefits, along with advice regarding appeals options;

(4) that benefits be continued to clients throughout their appeal before an Administrative Law Judge (ALJ).

- Senator Levin's S. 2725, considered an interim bill relative to S. 2674, would require that: (1) HHS slow down the number of CDI's; (2) Benefits be continued through the appeal level.
- Senator Riegle's S. 2776 would require: (1) that examiners must document medical improvement before benefits could be terminated; (2) that HHS slow down the number of CDI's; (3) that benefits be continued until an appeal hearing has been conducted.
- Congressman Davis' H.R. 6837 would require: (1) that examiners must document medical improvement before benefits could be terminated; (2) public comment before disability standards could be modified, and that uniform standards would apply to all levels of decision making; (3) that benefits be continued to clients throughout their appeal hearings.

Finally, should hearings be held, I urge you and your colleagues to consider a recent statement by Social Security Commissioner John A. Svahn who "once thought that Social Security's definition of disability was too loose, but now believes it is strict."[5] I further encourage you to heed the conclusions of two Social Security advisory groups which previously examined the disability definition and published the following findings:

According to the National Commission on Social Security (1981): "The Commission finds little evidence that the definition of disability in the law is too liberal or that it allows benefits to be paid to people who are able to work to support themselves."[6]

> According to the 1979 Advisory Council on Social Security: "...the council...recommends that a more liberal definition of disability be used for determining eligibility for SSI disability benefits..."[7]

Once again, thank you for the opportunity to comment on the federal disability program.

Sincerely yours,

C. Patrick Babcock
Director

CPB:AA/d

FOOTNOTES

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[1] Appeal by Denied Disability Claimants, Staff Paper 23, August 1976, Ralph Treitel.

[2] Disability Claimants Who Contest Denials and Win Reversals Through Hearings, Staff Paper 34, December 1979, Ralph Treitel.

[3] Social Security Survey of the Disabled, 1966 Report No. 11, September 1970, Philip Frohlich.

[4] State of Michigan Impact Paper on Proposed FY 1983 Definitional Changes in SSDI and SSI, June 24, 1982.

[5] "Disability Rolls Up, Official Calls It Mess," Lansing State Journal, August 29, 1982, pp 1A and 3A.

[6] First Report of the National Commission on Social Security, Social Security in America's Future, March 1981, p. 198.

[7] Reports of the 1979 Advisory Council on Social Security, Social Security Financing and Benefits, p. 148.

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5219 Birchwood Way
Lansing, Michigan 48917

June 23, 1982

Honorable Donald W. Riegle
United States Senator
1207 Dirksen Senate Office Building
Washington, D.C. 20510

Dear Senator Riegle:

I am writing on behalf of the Michigan Association of Disability Examiners. Our membership consists of professionals who work for the Michigan Disability Determination Service (DDS). The Michigan DDS is a state agency that works with the Social Security Administration by obtaining medical/vocational evidence and making decisions on Title II (Social Security Disability Insurance) and Title XVI (Supplemental Security Income) disability claims.

Since our job gives us a unique understanding of the disability program and its impact on claimants; we would like to make ourselves available to you and your staff. If you have any questions about the disability program in general or the Michigan DDS in particular, please contact us. In addition, we would like to receive information on proposed legislation so that we can assess its potential impact and provide you with feedback based on our knowledge of the program.

In order to facilitate this exchange of information, will you please designate a contact person in either your local or national office that we can communicate with regarding disability related issues. You can contact me by writing to the letterhead address.

Attached is some material that will familiarize you with our organization and some of our immediate concerns regarding continuing disability issues.

We look forward to hearing from you. Thank you for your interest and cooperation.

Sincerely,

Linda G. Largo
Linda G. Largo
President

LGL/dkh

Enclosures

Michigan Association of Disability Examiners
Chapter of National Association of Disability Examiners

made

MICHIGAN ASSOCIATION OF DISABILITY EXAMINERS - STATEMENT ON CURRENT PROGRAM INITIATIVES

Disability Examiners deal directly with the Social Security program regulations and procedures as well as with the claimants. We know first hand how the program works, its strengths and weaknesses. As a professional organization for Disability Examiners we would like to share our membership's concerns with you.

The Michigan Association of Disability Examiners supports the current Social Security initiatives to review, identify and remove from the rolls those beneficiaries who are not disabled according to Social Security criteria. This is currently being done through regular Continuing Disability Investigations and Periodic Reviews.

However, any Social Security Disability Investigation has a significant impact on the life of the beneficiary and his/her family. Periodic Review Investigations have an even more profound effect due to the fact that the reviews were not anticipated and because the claimant has been on disability (and out of the labor-market) for several years. There are several problems with the way these periodic reviews and other CDIs are conducted, which have resulted in undue hardship. For this reason M.A.D.E. would like to recommend the following changes:

BENEFIT CONTINUANCE

The two month grace period during which benefits are paid after the month of cessation should be lengthened to six months. A six month grace period would allow the claimant to pursue an appeal without immediate loss of benefits.

POLICY CHANGES

There have been several policy releases by SSA which, although issued as clarifications, have in fact been major changes in the disability criteria. One example of this occurred in the evaluation of claims involving mental impairments. For several years State agencies had been evaluating these claims under both the Medical Listings and the Medical/Vocational criteria. As a result many claimants who did not meet the Medical Listings were found disabled on a medical/vocational basis. In 1981 SSA issued a policy clarification which stated that mentally impaired individuals who did not meet the Medical Listings should be found capable of performing unskilled work. In almost all cases this would result in a denial or cessation of benefits. This type of change has resulted in beneficiaries who were correctly allowed benefits in the past now having their benefits terminated simply because the SSA program criteria have changed, even though their condition has remained tne same or worsened since they were allowed.

We recognize that as medical science progresses it may make a return to work possible by offering improved treatment methods which significantly reduce the disabling effects of some diseases and improving the prognosis in others. However, we feel great care must be taken to avoid ceasing benefits for those who continue to show the same level of severe limitations that were required by the original criteria under which they were allowed. Any major disability criteria policy change should be noted as such.

We also believe that the staff in the DDS should have greater opportunities for actual input in policy formulation. SSA should take advantage of the DDS personnel's first hand knowledge and experience in dealing with the SSA criteria. Social Security Disability criteria and documentation policies have sometimes required tests and information that are not commonly used in the medical community. These kinds of criteria and documentation requirements cause many public relation problems as well as unrealistic disability decisions. DDS could provide this kind of information to SSA before policies are formalized. Currently, DDS's are asked for input on changes which are ready to go into effect. For the most part our input is ignored. DDS personnel's opportunites for input needs to be expanded and their advice taken seriously at the Central Office level.

PROCESSING TIME

Expectations for DDS case processing time should be re-evaluated. We agree that providing a prompt decision is important. However, current trends to establish processing time requirements for all types of cases need to consider the time needed to effectively pursue and obtain all the evidence from the claimant's own treating sources and to meet the legal requirements of due process. By allowing more time to get reports from the attending physicians we would strengthen claimant and public confidence in the medical decision. In addition, processing times established should take into account SSA's expectations of case development and should allow the DDS reasonable time to meet these expectations.

FEDERAL CASE REVIEW

Current SSA review of DDS disability decisions is focused heavily on allowance and continuance decisions. This often results in perceived pressure on the DDS to deny or cease benefits due to the higher potential for review of favorable decisions. The Social Security Administration's review of DDS's decisions should be random with no emphasis on allowances, denials or particular types of impairments. This will require a change in the 1980 Amendments.

V. R. FUNDING

Many beneficiaries who are terminated as a result of Periodic Review have been on Social Security Disability, and out of the labor-market, for several years. Regardless of their age, these people are usually ill-equipped to re-enter the competitive job market successfully. We believe that all individuals who have had a medical disability for more than seven consecutive years, as established by SSA guidelines, should have the option of entering a vocational training program at SSA's expense if Social Security review finds they are no longer medically disabled. Benefits should be continued so long as they remain in the training program and would be ceased upon completion of that training program. Training programs must be realistic and job oriented. Tax incentives should be provided to both public and private industry that employ beneficiaries who are no longer medically disabled. This will also require a change in the 1980 Amendments.

UNNECESSARY REVIEW

Beneficiaries are occasionally subjected to unnecessary stress because of inappropriate periodic review. In order to prevent this it is recommended that the Social Security Administration expand the list of permanent impairments which are excluded from the review process. The list of permanent impairments should be expanded to include: (1) impairments which have been sufficiently documented as severe and are known to be progressive. Examples would be certain central nervous system disorders such as amyotrophic lateral sclerosis, Parkinson's Disease, Huntington's Chorea and paralysis or aphasia 3 months post CVA. These impairments are known to be permanent, progressive and incurable. (2) Impairments which have been previously assigned a specific permanent, mandated residual functional capacity which would result in a vocational allowance. An example of a situation where this would apply would be the replacement of a hip or knee which automatically precludes heavy or medium work activity. (3) Beneficiaries age 55 or older should not be included in the Periodic Review Process, although they could be included in other types of continuing disability investigations.

In addition the DDS should be given more latitude in screening out claims on the basis of individual case facts.

This recommendation would reduce increasing workload and cost expenditures for the DDS.

The Social Security Administration should increase communication with the States, legal organizations, claimant advocacy groups and the medical community. The general public needs more concrete information regarding the Social Security Disability program requirements. Social Security Administration should continue to supply the medical community with the medical criteria. Special announcements about policies and policy changes in the medical criteria used by the Social Security Administration should be publicized. This increase in communication would in turn, lead to increased understanding of the Social Security Disability Program and be beneficial in obtaining the needed cooperation from the medical community when medical evidence is requested. This could result in obtaining more complete medical evidence from the claimant's own medical sources. In addition, the Social Security Administration would benefit by a reduction in the need for cost development with outside medical sources if more complete medical evidence were supplied by treating physicians.

ADVANCE STAFFING

Major program changes which will require training of current staff or hiring of new staff, need to allow for DDS preparation time. Too often major changes are effective immediately without allowing adequate preparation time - or, if additional staff is needed to comply with the changes, hiring is delayed due to lack of funds. Lead time of at least one year should be provided before major program changes are implemented. Adequate funding for this must be provided by Congress. We do not object to changes or to additional work. But we do object to lack of lead-time and understaffing for changes which affect our work.

UNIFORMITY

Finally, we feel it is important to insure and maintain uniformity between and among the basic SSA components. The same laws, regulations, and medical criteria should be used by all the various components. Therefore, the ALJ should be bound by the same laws and regulations as the DDS. We support the concept of a Social Security Court.

RETROACTIVE CESSATIONS

We support and applaud the Social Security Administration's recent changes in regard to retroactive cessations.

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VOCATIONAL REHABILITATION DIVISION
SOCIAL SECURITY
DISABILITY DETERMINATION SERVICES
TELEPHONE (612) 296-2574

August 20, 1982

Senator David Durenberger
353 Russell Office Building
Washington, D.C. 20510

Attention: Barbara J. Washburn

Dear Senator Durenberger:

On August 18, 1982, I had the privilege of accompanying Mr. Edwin Opheim, Assistant Commissioner for Vocational Rehabilitation, as a witness at the Senate Finance Committee hearing on Social Security Disability Insurance. Unfortunately, due to time constraints, there was no opportunity to receive questions from members of the committee. Therefore, as you advised, I am submitting this letter for your consideration and entry in the Congressional Record.

The problems which have accompanied the "Periodic Review CDI" program have generated a search for solutions both in Congress and within the Social Security Administration. At least one of many ideas offered as a partial solution has received rather popular support and, I believe, is offered in one form or another in at least three separate Bills now before Congress. The concept is contained in Senate Bill 2731, and is supported by the Social Security Administration. The proposal is to conduct face-to-face hearings either at or in place of the reconsideration level of appeal. These hearings would be conducted by Disability Examiners from the various State Agencies, and would be conducted for beneficiaries who have had benefits ceased or proposed for cessation. The hope for such hearings is that they will provide for more equitable decisions, elevate the reconsideration process from the status of a "rubber stamp" affirmation of the original decision, and possibly bring some harmony to State Agency and Administrative Law Judge decisions.

Admittedly, the idea appears so logical and valid as to be almost a truism. However, I have serious doubts that such a process will result in the sort of changes envisioned by its proponents.

Disability Examiners, in adjudicating claims at both the initial and reconsideration level, are bound by a set of administrative rules which are not binding on Administrative Law Judges. The very purpose of these rules is to provide for uniform and consistent decisions by Disability Examiners throughout the nation. I firmly believe that it is the different adjudicative frameworks within which Judges and Examiners operate, which accounts for the differences in their respective decisions. This conclusion is supported by "The Bellmon Report", submitted to Congress by the Secretary of Health and Human Services in January, 1982.

Given the policies under which Examiners must operate, no amount of face-to-face contact, personal observations, empathy or human sympathy should alter the outcome of a State Agency decision. Such decisions must be based on objective medical evidence within a rigid framework of rules and policies. Examiners will not become "mini-judges" with greater individual discretion in decision making, simply as a result of conducting interviews.

While there may be a very reasonable expectation that face-to-face interviews might elicit additional information regarding medical sources which should be contacted, or additional allegations of impairment, such information might well be more easily obtained simply by telephone contact or improved forms and letters. In terms of accuracy of decisions being made on the evidence in both initial and reconsideration CDI cases at present, the most recent statistics available to me from SSA indicate a national accuracy rate of 95%.

There are also adminstrative reasons, I believe, which deserve further consideration before mandating implementation of such a process on a national basis. The cost of such a program would be considerable, and would certainly indicate the need for current "hard" evidence that the program can be expected to produce the intended results. State Agencies, if they are expected to undertake another major program change, would need more lead time than one year. Experienced Examiners, the very people who would conduct such hearings, have never been recruited or trained for interview skills, nor are they equipped to deal face-to-face with attorneys and other legal representatives who would attend such hearings.

I would suggest that any face-to-face interview program be thoroughly tested before mandating it for national implementation. I believe a well-constructed pilot-study, to be conducted in several states in the current adjudicative climate, would be a most valuable action before any final decision is made.

I wish to thank you for your consideration of these comments.

Sincerely,

Walter J. Roers
Assistant Director, Operations
Disability Determination Section

WJR:wc

cc: Robert Sternal, Director DDS
Ed Opheim, Assistant Commissioner, Voc. Rehab.
Donna Mukogawa, Disability Program Administrator

SOCIAL SECURITY DISABILITY INSURANCE PROGRAM

for the

SENATE FINANCE COMMITTEE

SENATOR ROBERT DOLE, CHAIRMAN

written by

Michael Lomax, President

National Association of Disability Examiners

August 30, 1982

Mr. Chairman,

Thank you for granting the National Association of Disability Examiners the opportunity to submit written testimony regarding the review of Continuing Disability Claims under the Social Security Act.

The National Association of Disability Examiners is an organization of members from the State Agencies contracted to implement the review process. The members of this organization are at the grass roots of the disability process and are on the front lines of the review process. The professional disability examiner has first hand knowledge of this review process and how it effects not only the claimant, but also the Social Security Disability Trust Fund.

Throughout the years the major workload of the disability process has been at the initial claims level. Initial determination processing was the priority of the Social Security Administration. The Continuing Disability process through these years took a low priority beginning with S.S.A.'s oversight of the Supplemental Security Income program. Priority was given to placing claimants on the roles who met the disability criteria at that time.

Due to the 1973 legislation Continuing Disability Investigation of both Social Security Disability and Supplemental Security Income claims was often delayed beyond the scheduled reexamination time and often ignored.

This decision was made at the national level by S.S.A. in order to accommodate the large influx of initial disability claims. Evidence exists in many claims folders to show that Continuing Disability Investigations were delayed or cancelled by S.S.A. and not by the State Agencies.

True, the claimant may have received a letter in 1974 indicating their claim would be reviewed in two years, however due to SSA's reluctance to return these cases this review did not take place until recently. I can certainly understanding their confusion. A claimant might have received a letter in 1974 with notice of a review to take place in 1975 or 1976, and 5 to 6 years later the review begins. In that extended period of time the claimant has become dependent on the monthly income from S.S.A. The current process of notification of investigation, development, review, and final processing prior to cessation can take from a few weeks to a couple of months. This is too short of a time frame for the claimant to make adjustments from receiving a check to no check.

The criteria by which disability determinations are made have changed over the years. These changes have had a dramatic impact on the disability process. Both a need to tighten disability requirements and major advances in some fields of medicine have resulted in substantial changes in the listing of impairments and S.S.A. policies. We believe these changes in the criteria are both necessary and justified to insure that the Social Security Disability program remains dynamic. Medical Science has advanced much in the last twenty years. Claimants that would have been considered totally disabled with no hope for medical improvement are capable of productive and useful lives today. I do not believe it would be the intent of Congress to continuing paying claimants based upon a disability that no longer exists.

Several Congressional proposals have been introduced which would limit the Continuing Disability Invesitgation process to the disability criteria in force at the time of the initial granting of disability benefits. Such a restriction would only reinforce the false concept of "retirement on disability" and deny to Congress and S.S.A. advances in medicine and the flexibility to adapt to changing economic and political conditions. Of course, claimants presently on the roles would take a dim view of this. The delay in returning claims to the State agencies for reviews has prompted Congress through GAO to review this process. The results were horrifying to the Administration and Congress but only confirmed the examiners concerns. The mandatory 3 year review required by the 1980 ammendaments, the Presidents' recommendation to start the "accelerated" and "profile" review processes immediately, reached the State agencies at the approximately the same time. This resulted in backlogs of thousands of cases in State agencies. This process of reviewing disability claims has become a night mare in the eyes of the Professional Disability Examiner.

These cases are being reviewed by the most qualified examiners. However, examiners are pressured to process not only this workload but the initial workload as well. State Agencies performance standards only consider initial caseloads. The current workload trends in the State Agencies have forced examiners into an uncontrollable workload of hundreds of cases per examiner. The review and development of these cases takes time. Examiners are pressured to move cases faster resulting in incomplete medical documentation. Examiners are human beings with human limitations.

The pre-effectuation review of allowances and continuances established by congress tends to influence the examiner to make a decision of denial or cessation because it is, statistically speaking, less likely to be found in error.

Examiners do admit the current medical criteria is difficut to meet. We certainly understand the claimants point of view. However, we as Professional Disability Examiners are implementing a disability program established by Congress and administered by S.S.A. We do feel the criteria in effect should be reviewed and revised as necessary.

We find a repugnant situation in the appeals process. The complete disregard by which some Administrative Law Judges review and adjudicate disability claims is totally juxtaposed to the strict guidelines to which disability examiners are held by the Administration. This evidence is supported by the results of the "Bellmon report" presented to Congress earlier this year.

The Continuing Disability Investigation process includes claims allowed by both the State Agencies and the A.L.J. State agencies often find themselves in the position of ceasing claimants initially allowed by the A.L.J. only to have their decisions again reversed by the A.L.J several months later. This has added complete turnmoil to the lives of claimants. One component of the agency stating they are not disabled and another component saying they are disabled. The decision is supposedly based upon the same evidence. These two components need to use the same rules in making a decision.

The problems facing the disability program are numerous. G.A.O has determined this program to be the most complicated of all Federal Programs. With this in mind Congress must take steps to correct these inconsistences to present a just and fair program to the public:

1. S.S.A should reconsider the stringent criteria now in force and reevaluate the requirements needed to meet disability.

2. Congress and S.S.A. should establish a moratorium on the performance standards now imposed on the State Agencies.

3. A moratorium should be established on the additional Continuing Disability cases, now being sent to state agencies until the current backlogs are eliminated.

4. Establishment of a review process by Physicians, Congress, and professional Disability Examiners before revisions are made in the disabilitity requirements.

5. More uniformity between State Agency and A.L.J. decisions.

6. Establishment of expanded education opportunities for Physicians, Examiners, and Administrative Law Judges.

This concludes my testimony and again, we the National Association of Disability Examiners thank you for the opportunity to submit testimony.

Statement of

John L. Melvin, M.D.

President

NATIONAL ASSOCIATION OF REHABILITATION FACILITIES

Mr. Chairman:

Introduction

My name is John Melvin. I am President of the National Association of Rehabilitation Facilities (NARF). NARF has 500 institutional members who provide comprehensive rehabilitation services to over 400,000 disabled individuals annually. Many of these people are Social Security Disability Insurance beneficiaries and Supplemental Security Income disability beneficiaries. This statement is addressed primarily at the beneficiary rehabilitation program under the SSI and SSDI programs.

The SSDI program provides benefits and rehabilitation services to persons determined to be disabled and therefore unable to work. It contains incentives for people to seek employment, however several disincentives still exist. Prior to the Omnibus Budget Reconciliation Act of 1981, the beneficiaries vocational rehabilitation program was a main feature of the SSI and SSDI programs in returning disabled people to competitive employment. It had managed to achieve a margin of success in returning people to work and removing them from the benefit rolls. However, the 1981 Reconciliation Act amended the program and we believe rendered it useless. We support incentives and services to help beneficiaries to become self-sufficient. To this end NARF offers the following comments.

Vocational Rehabilitation Program

Prior to the Omnibus Budget Reconciliation Act of 1981, the SSDI vocational rehabilitation program authorized funds to be paid from the OASDI trust funds to state agencies for services delivered to SSDI beneficiaries. The purpose of the program is to return beneficiaries to work, thereby resulting in savings to the trust funds.

In 1981, $124 million was available under the program for both SSI and SSDI beneficiaries. Approximately 150,000 people were served. Several studies were done on the program, all of which showed it to be cost effective.

In his FY 82 budget message, President Reagan proposed to repeal the program as part of his overall budget cutting effort. Congress did not completely accept this proposal; however, it did amend the program. The new provision provides that states will be paid, either in advance or by way of reimbursement for successful rehabilitations. A successful rehabilitation is defined as a person who is performing substantial gainful activity (SGA) for nine (9) continuous months. SSA issued proposed rules stating that it did not intend to make any payments in advance and that it anticipated only $3 million being available under the program for FY 82. The President's budget requested only $6.1 million for the program in FY 83. States had until April, 1982 to indicate whether or not they would participate.

There are several major problems with the statute as amended. First, the provision severely limits the availability of funds for rehabilitation of SSI and SSDI beneficaries which will result in continued dependence of many beneficiaries on cash assistance. Also, states are expected to use funds under Title I of the Rehabilitation Act of 1973, as amended, to provide services which hopefully result in a successful rehabilitation. If not, they are not reimbursed. Use by the states of these increasingly scarce funds for SSI and SSDI beneficiaries is unlikely given the uncertainty of reimbursement.

Funds for the basic state grant program under Title I of the Rehabilitation Act of 1973 have been diminishing steadily. In fiscal year 1981, $854.3 million was available to serve disabled people. The program was increased only marginally by approximately 5% for FY 82 to $863 million. In his FY 83 budget request, the President proposed a $91 million recission for FY 82. For FY 83 the President requested only $579.5 million for state grants. According to recent figures from the Rehabilitation Services Adminstration, Department of Education, 353,000 fewer people would receive services at this FY 83 level. This is 28% below the 1982 levels. This potential decrease from the FY 82 levels is in addition to the expected decrease from the 1981 to 1982 and the 9% decrease in services from 1980 to 1981, not counting the effects of inflation.

While the First Concurrent Budget Resolution for FY 83 assumes full funding of the basic state grant program at $954 million, the final level will be determined by the appropriations process. Given the virtual elimination of the beneficiary rehabilitation program, and cuts in the basic state grant program, state agencies are and will have to continue to turn away numerous clients including SSI/SSDI beneficiaries.

We believe Section 11 of S.2731 introduced by Senators Heinz and Durenberger goes a long way toward resolving some of these problems. We do, however, have several comments.

The bill would require payment for services delivered to be paid in advance. In fact, since this issue was raised with SSA it has announced that it will pay states in advance. This bill would assure continuing advance payment.

The bill would allow the Commissioner of the Social Security Administration to contract directly with public and private organizations to provide vocational rehabilitation services. Payment would be made through a transfer from the trust funds for the costs of these services. We support this provision. NARF has sought to have direct referrals made to facilities in order to expedite evaluation of clients, preparation of a rehabilitation plan and delivery of services.

The bill also expands the scope of payments to include evaluation services as determined by the Commissioners of SSA, services contributing to medical recovery, and services delivered if the person without good cause fails to cooperate, in addition to paying for successful rehabilitations. While this expansion of circumstances for which services will be paid is helpful, it still leaves open the question of covering the cost of delivering services to individuals not achieving 9 continuous months of SGA.

If the program is going to reimburse private rehabilitation facilities or states only in these four circumstances, both facilities and states will be at risk for good faith efforts to rehabilitate a beneficiary that does not result in a successful rehabilitation. The state agencies can use basic state grant program funds to cover such costs. Such funds would otherwise be available for clients under that program. State agencies would have funds to draw upon and not risk an outright loss.

Private facilities would have to pay funds for services out of their own capital thereby decreasing their service capacity. It would be imprudent for the trustees of a facility to accept referrals if they must pay the cost for services whether the rehabilitations are successful or not, unless there is potential for financial reward concomitant with the risk. As drafted there is no way to average out the failures. Even the best evaluation techniques do not guarantee 100% success.

Therefore, if facilities accept such referrals and the risk that the client might never achieve 9 continuous months of SGA, there should be an incentive and reward for doing so. If the only cost paid is for successful rehabilitations and none for unsuccessful ones, the facility can, at best, only come out even. Most will always be losing funds.

We recommend that in those instances where facilities contract directly with the Commissioner, that an incentive payment in the form of a premium over cost be included in facility payments. We suggest a premium over cost of services retained, recognizing that if such services are not sucessful, reimbursement will be zero.

The bill also proposes to pay states for vocational evaluation and job placement services provided to people who medically recover and who are determined to be no longer disabled as a result of a continuing disability investigation (CDI). Such services are needed by people who have been disabled and not working to help them determine and learn employment skills. We recommend that the legislative history make it clear that states can contract with private rehabilitation facilities for these services.

The 1980 SSI/SSDI amendments established an experimental and demonstration project authority. The bill would expand this to include exploring ways to use private rehabilitation facilities to provide services to beneficiaries. It speaks in terms of organizations organized for profit and those not so organized. Current language favors the for-profit sector. If the intent is to include both private for-profit and non-profit organizations, we recommend that it should be specifically so stated. We do support the idea of demonstration projects with rehabilitation facilities and placing specific time limits on the Department to conduct the projects. To date it has not implemented the section of the 1980 amendments establishing an experimental and demonstration project authority.

The Administration in its testimony stated that it did not support this provision because it would result in an unnecessary expenditure of funds for vocational rehabilitation. We find this stance curious.

First, during the House subcommittee markup on their bill, upon direct questioning, the Administration's representatives said they did not oppose the same provision. Second, the BRP program has been shown consistently to save the trust funds money. Given that the funds for all other social service programs serving the disabled (including SSI and SSDI beneficiaries) such as the Rehabilitation Act, Developmental Disabilities, Title XX, P.L. 94-142, medicare and medicaid have been reduced over the past two years, failure to continue successful programs will compound the problems of dependence and required continued reliance on some form of benefits or other public assistance. Third, the OASI and OASDI funds (commonly referred to as the Social Security Trust funds) are in financial difficulty. This provision would reinvigorate a program which would, for a very small investment (in budget terms) of approximately $30 million, result in long term savings in benefits not paid out by the trust fund but with contributions made instead, and no need to limit, reduce or eliminate benefits to qualified disabled beneficiaries.

We appreciate and support this provision of Senators Heinz and Durenberger's comprehensive disability reform bill and have several other comments on the bill and the program. They are:

Continued Benefit Payments (Sec. 2)

We have received reports from our members of the number of people undergoing review of their disabling condition pursuant to the 1980 amendments. Many of these beneficiaries have not been reviewed in years and are suddenly faced with a loss of benefits before their appeal is exhausted.

We support this provision to allow SSDI beneficiaries to continue to receive benefits through the appeal period as do SSI beneficiaries currently.

Adjustment Benefits (Sec. 3)

This provision would allow a person terminated as a result of the continuing disability investigations currently being conducted to continue to receive benefits for a total of four months after the month he or she is notified of being terminated for medical recovery. This provision would be in effect through 1984 by which time all the rolls will have been reviewed. Such people could also receive vocational work evaluation and job placement as proposed in Section 11. We support this provision as a way of easing the economic shock of a sudden loss of benefits and helping people obtain employment.

Substantial Gainful Activity (SGA) and the Trial Work Period (TWP)

Under existing Social Security Administration regulations, any calendar month in which a disabled recipient earns more than $75 in gross wages may be counted as one month of the trial work period. This regulation makes it possible for disabled employees of sheltered workshops to exhaust all or part of their trial work period before they are ready to attempt independent, community employment. For example, evaluation and training involve productive work in providing such services. Especially in the case of the more severely handicapped, such training is extensive and may exhaust the trial work period. We are unaware of any justification for the $75 earnings level for a trial work period month. Even by linking this amount to COLA increases, the test will continue to deprive many sheltered workshop employees of a meaningful trial work period. Because this requirement performs a substantial disservice to disabled workers, we recommend that it be removed.

Another problem associated with the trial work period is the confusion regarding what remuneration constitutes income, which is denoted as "services" in the statute. In the House bill, H.R. 6181, "Services" are to be defined as activity which is determined by the Secretary to be of a type normally performed for remuneration or gain or which is performed in any month for remuneration or gain. Currently, there is no specific list of such services in the SSI Claims Manual or elsewhere.

In determining a TWP month, disparate sources of income are considered to constitute services. For example, one inconsistent source of income used to determine a TWP month is the CETA training allowance under Title II. These funds are counted against TWP income, but are specifically excluded from income in determining SSI eligibility.

If income is to determine the existence of "services" for purposes of TWP, the type of income that constitutes services should be consistent in determining eligibility and SGA.

Productivity as measured by income, not the work attempt, should determine SGA.

Second, the amount that constitutes SGA should be monitored to assure that it does not increase to a level where it becomes a disincentive to leaving the program and seeking competitive employment.

We recommend the Committee examine this issue in its consideration of the SSI and SSDI programs.

NARF would be pleased to provide any additional information on these and any other issues under these programs.

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Written Statement of Eileen P. Sweeney, Staff Attorney at the National Senior Citizens Law Center, to the Committee on Finance, U.S. Senate (August 18, 1982)

I am Eileen P. Sweeney, a staff attorney at the National Senior Citizens Law Center (NSCLC). This statement is submitted in response to a request from Senator John Heinz for such a statement.

NSCLC is a national support center, specializing in the legal problems of elderly poor people. We are funded by the Legal Services Corporation and the Administration on Aging. Pursuant to the Law Center's Legal Services Corporation grant, we provide support services to legal services attorneys and paralegals throughout the country with respect to the legal problems of their elderly clients. Under the Administration on Aging grant, NSCLC provides training and planning assistance to the states and is developing strategies to resolve the legal problems of older people without the direct delivery of services. My responsibilities include working with legal services and aging advocates on the Social Security and Supplemental Security Income problems of their clients.

The problems created by the Social Security Administration (SSA) in the continuing disability investigations (CDIs) have reached a crisis level both in terms of the number of eligible disabled beneficiaries being cut from the rolls and in terms of the great emotional and financial hardship being imposed upon these severely disabled individuals. The incredible stories of human misery and suffering have appeared in the press across the country. Yet, not only has SSA not taken steps which would assure that disabled individuals are not cut, it continues to cut people daily. The cessation rate is between 45-47%. This year alone SSA will review 565,000 cases. Next year, it intends to review 800,000. Just between October, 1981 and May, 1982, SSA terminated the cases of 106,000 disabled individuals and their families. That number will continue to climb. While many of these people will eventually be returned to the disability program (the reversal rate on appeal is currently around 60%, although in some areas of the country it exceeds 80%), the damage to their lives created by the terminations is often irreversible.

These are not isolated incidents. The patterns of treatment by SSA and state employees are repeated throughout the country. The unnecessary personal crises created by SSA vary only slightly in each case: families are losing their homes; they are unable to feed their children; some have relinquished their children to relatives to assure they receive proper care; some beneficiaries have died. The deaths seem to follow four patterns: (1) in complete despair, the person committed suicide; (2) in complete despair, the person withheld his medical treatment and died; (3) the pressure and tension resulting from the CDI termination aggravated and expedited the person's death; (4) the person, despite the severity of his impairments, returned to work (as SSA maintained he could) in order to feed his family and died shortly thereafter. No one knows how many individuals have died as a result of SSA's harsh policies. Surely this is not what the Congress had in mind when it passed §311 of Public Law 96-265.

This is thus a very important hearing which presents the opportunity to investigate SSA's abuses of power and to consider solutions to the CDI crisis. This statement will begin with a general discussion of the CDI problem and discuss legislative changes needed to alleviate the crisis. The second section discusses some specific practices of the Social Security Administration which, in combination with the acceleration of the CDIs, or as a result of the CDIs, are clearly contributing factors in the crisis and which must be rectified.

I. There must be a significant change in attitude in the administration of the CDIs.

Over the past few years, there has been a change in tone in the disability programs. Without much written instruction, all the signals are that state disability personnel should cut the rolls and keep them small. This has resulted in the termination of severely disabled individuals as well as the denial of new applicants. These signals include:

- requirements that SSA review allowances but not denials or terminations;
- excessive emphasis on speed to the exclusion of accuracy;
- as a corrollary, the failure to require states to assure that there is adequate evidence development;
- public discounting by SSA of the currently high administrative law judge (ALJ) reversal rates, arguing that it is the ALJs who are out of step with SSA and ignoring the growing problems at the state level;
- statements indicating that SSA is affecting budgetary

savings in the disability program by terminating high percentages of allegedly non-disabled persons;

- statements indicating that the decision regarding which case to review is being based, not upon the likelihood of medical improvement, but upon the amount of the person's monthly benefit (the higher the benefit, the greater the chances for review).

The Administration is effecting the budgetary savings in the disability programs by cutting eligible people, exactly what Congress refused to do just last year. SSA has gone so far as to attempt through a variety of means to influence the outcome of decisions by ALJs. In one memo, dated May 7, 1981 (attached as Exhibit "A"), the Associate Commissioner at the Office of Hearings and Appeals wrote to ALJs to express the concerns of the Commissioner and to inform ALJs of the "seriousness with which he views the SSA effort to throughly review those cases of individuals now on the rolls to determine whether they still fully meet all requirements for entitlement."

As witnesses will establish at the hearing, severely disabled individuals are being terminated without adequate medical evidentiary development and despite the fact that they are totally incapable of working. Often the only documents supporting these arbitrary and incorrect decisions are the inadequate reports of consultative examiners. In some cases, however, cases are being terminated even where the consultative examiner believed the person to be disabled.

All indications are that SSA is concerned with speed, not accuracy, in the disability determination process. That message has been provided very clearly in the SSA regulations governing the federal-state relationship. 20 C.F.R. § 404.1601 et seq. These regulations do not even require that medical evidence be properly and fully collected. They do, however, set up numerous time frames with which the states must comply. While we agree that the states should be required to operate efficiently, timeliness is not beneficial to claimants and beneficiaries (in the CDIs), if it results in wholesale inaccuracies in decisions. It is similarly not cost-effective for SSA because claimants who do not believe they received full and fair consideration will appeal. There has been no effort to assure accuracy in the process.

The message must be changed. First, SSA should be required to amend its regulations to shift the emphasis to assuring accuracy in decision-making at the state level. To reinforce this shift, SSA should be required to review disallowances in the same fashion. that they currently perform pre-effectuation review of allowances. It is not adequate to argue that the ability to appeal the denials is a self-policing mechanism rendering review of disallowances unnecessary. If that was true, SSA would currently be questioning the state's abysmal records rather than attacking the ALJs' high reversal rates. SSA simply does not view ALJ reversals as any reflection upon the accuracy of state agency decision-making. The result is that the easiest, least monitored, route for the states to take is to deny or terminate benefits, regardless of the severity of the person's impairments.

In addition to requiring review of disallowances as well as allowances, we recommend that Congress take the following steps to change the message in order to assure that CDIs are performed properly and that claimants receive full protection from SSA and state agency abuses:

(1) Provide aid pending review in the Title II program through the ALJ level and that any payments received during the appeal process will not be treated as an overpayment should the person not ultimately prevail on the merits;

(2) Amend the definition of disability to clarify that, before a person's disability benefits may be terminated, there must be a showing that his/her medical condition has improved or that the original decision awarding benefits was clearly erroneous. This last point is consistent with the rulings of numerous federal courts which SSA has illegally chosen to ignore;

(3) Slow down the CDI process to prohibit SSA from terminating nearly 400,000* individuals next year alone;

(4) Limit the ability of states and SSA to rely upon the opinions of non-examining "medical advisers;" and

(5) Require SSA to (a) issue regulations detailing its standards of conduct for consultative physicians and (b) fully monitor the consultative physicians utilized by SSA and the states in the disability determination

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*If SSA performs the 800,000 CDIs in 1983 which it currently plans, at its current termination rate of 45 to 47%, as many as 376,000 disabled individuals will lose their benefits next year alone.

process.

II. Specific problems.

A. The reconsideration level of review

The reconsideration level of review is generally considered to be useless. In almost all states, it simply results in a rubber-stamp approval of the original decision to deny or terminate benefits. It generally serves to delay the time at which a person may first seek review before an autonomous administrative law judge. Many believe that the wisest solution to the problem would be to eliminate this level of review.

Representative Pickle has proposed steps to "strengthen" the reconsideration level of review in H.R. 6181 (formerly H.R. 5700). Unfortunately, the appellant will bear the entire burden of cleaning up this administrative nightmare. Nothing in that bill provides any incentives to either SSA or the states to properly adjudicate cases.

One provision of that bill will close the evidentiary record before a person ever appears before an administrative law judge. The vast majority of claimants are not represented at the reconsideration level. They are not familiar with the evidence required to support a finding of disability. Yet, they alone will bear the burden of assuring that the states improve their evidence development practices. This approach is unrealistic, unfair, and destined to fail.

First, it is unfair to expect that claimants will serve as police officers. The price which they pay is delay. Bouncing back and forth between the federal and state levels will add new elements of delay to the process. The ALJ will be required to review all of the evidence to determine if a remand is appropriate. Then, the case will return to the states, and then back to the ALJ. Very few cases are reversed at the reconsideration level. It is therefore likely that the case will return to the ALJ stage. Unrepresented disabled claimants and beneficiaries will be required to obtain all medical and vocational evidence on their own. The ALJs will no longer be there to assist and, with rare exceptions, the state levels have not provided that assistance.

It is not realistic to expect that claimant-sought remands to the state agency level so that additional evidence may be introduced will result in a systematic clean-up of the reconsideration stage. Instead, it is more likely that the current problems will simply escalate: state agencies will deny cases, continuing to provide poor evidence development, knowing that claimants will appeal and, if they can obtain the evidence on their own, be forced to seek a remand. The Congress has already taken steps to remedy an analogous abuse in the SSA appeals procedure: prior to P.L. 96-265 the Appeals Council regularly failed to properly review appeals, knowing that they could easily obtain a court remand if judicial review was sought.

B. SSA "non-acquiescence" in court rulings

SSA has developed the nasty habit of ignoring rulings of the United States Courts of Appeals. They do so despite the fact that they have specifically informed the United States Supreme Court that their policy is the exact opposite. In Califano v. Yamasaki, 442 U.S. 682 (1979), the Secretary argued that certification of class action was not necessary because he followed rulings of the Circuit

Courts of Appeals.* Despite these representations to the Supreme Court, to which that Court specifically referred, SSA's true policy is that it will only follow decisions of the Supreme Court. A memo from Louis B. Hays, Associate Commissioner of the Office of Hearings and Appeals, to all ALJs, dated January 7, 1982, specifically states:

> "Frank Dell'Acqua [Deputy Assistant General Counsel, Social Security Division] stressed the point that the federal courts do not run SSA's programs, and that ALJs are responsible for applying the Secretary's policies and guidelines regardless of court decisions below the level of the Supreme Court..." (Exhibit B, page 3)

But, despite the fact that the Secretary frequently loses cases in the Courts of Appeals, he rarely appeals.* Conveniently, under his policy, because he does not appeal to the Supreme Court, there will not be a Supreme Court decision which he would have to follow. This means that he can simply award the named plaintiff benefits while otherwise ignoring the problem.

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*"Restricted judicial review will not have a detrimental effect on the administration of the Social Security Act, the Secretary says, because he will appeal adverse decisions or abide [by] them within the jurisdiction of the courts rendering them." 442 U.S. at 699. In its Brief for the Petitioner in Yamasaki, at pages 68-69, the Secretary specifically stated:

> Contrary to the fears of the courts of appeals that have endorsed class actions under (§405(g)), that restricted version of judicial review permitted by that statute will have no detrimental effect on the efficient resolution of Social Security Act claims. When a statutory or constitutional issue is decided adversely to the Secretary in the course of judicial review obtained by an individual claimant, the Secretary will either appeal or abide by the unfavorable ruling. See Philbrook v. Glodgett, 421 U.S. 707, 720-772 (1975). Repetitious litigation will thus not be necessary in order to establish a general legal principal applicable beyond the confines of a particular case. (At this point, a footnote adds, "In some cases, however, additional litigation of an issue in additional jurisdictions is desirable. See pages 75-76, infra.) Stare decisis will impel the Secretary to follow statutory or constitutional decisions within the jurisdiction of the courts having rendered them. [Brief for the Petitioner (Secretary of the Department of Health and Human Services) at 68-69, Califano v. Yamasaki, supra (emphasis added.)]

A problem currently existing in the Ninth Circuit is an excellent, well-documented example of this incredible problem. In *Finnegan v. Mathews*, 641 F.2d 1340 (9th Cir. 1981), the Ninth Circuit ruled that the Secretary could not terminate the benefits of SSI disability recipients who had been "grandfathered" into the program from state disability rolls when the SSI program began, *unless* SSA established that either the "recipients' medical condition has materially improved" or that there was "clear and specific error" in the original finding of disability. In other

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*It is possible that SSA will claim that is is now filing appeals in the Supreme Court in cases in which it non-acquiesces, citing *Campbell v. Secretary of HHS*, 665 F.2d 48 (2d Cir. 1981), *cert. granted sub nom. Schweiker v. Campbell*, No. 81-1983, 50 U.S.L.W. 3994, June 21, 1982. In that case, SSA recently issued a ruling of non-acquiescence, SSR 82-33c. However, in order to justify all of this activity, SSA has misconstrued the Second Circuit's ruling. The court required that SSA give a disabled appellant notice of the presumptions which it intends to apply in his/her case, and to explain what the presumption means, in order to assure that he/she is in a position to attempt to rebut the presumption. This is required by SSA's own regulations. See Rule 200.00(e) of Appendix 2, 20 C.F.R. Parts 404, 416. Instead of adhering to the court's order, at least in the Second Circuit, SSA has taken the position that the case invalidated the medical-vocational guidelines (the "grids") and that, therefore, there is a conflict among the circuits. This of course raises serious questions regarding the intent of SSA to follow its own regulations with regard to the grids. It also calls into question the numerous circuit court of appeals decisions which have upheld the validity of the grids, often relying upon the Secretary's regulatory language for the protections to be provided claimants and the exceptions to application of the grid. See, for example, *Kirk v. Secretary of HEW*, 667 F.2d 524 (6th Cir. 1981).

words, SSA can not apply its current regulations to cut a grandfathered person off as that would defeat the underlying purpose of the grandfathering language of the SSI provisions.

SSA did not like the Finnegan ruling. But, unlike other disgruntled litigants, it decided not to appeal to the Supreme Court and, instead, "non-acquiesced" in the ruling. SSA's thought process here are particularly instructive. In a September 14, 1981 memo from Sandy Crank, Associate Commissioner for Operational Policy and Procedures, to Donald A. Gonya, Assistant General Counsel, (attached as Exhibit C, Sandy Crank outlined the following reasons for not appealing:

1) "...according to our review of the medical evidence in file, it is questionable whether Finnegan is in fact not disabled at this time." (page 3) Simply put, SSA had defended the Secretary's termination of benefits all the way through the Ninth Circuit, despite the fact that even they believed that Mr. Finnegan was disabled.

2) "Mistakes were made in the legal defense of this case before the Court of Appeals." (page 3)

He then recommended that SSA "non-acquiesce" in the court's order and wait for a case with poorer facts to take to the Supreme Court:

> "With a non-acquiescence ruling, we can attempt to argue this issue again before the courts in a case in which the plaintiff is clearly not disabled, where the State disability determination is in fact not available and where the case can be prepared properly without the legal flaws found in Finnegan. The Office of Hearings and Appeals agrees with this course of action." (Id.)

So, in January, 1982, SSA issued Social Security Ruling 82-10c, "non-acquiescing" in Finnegan. And, as if that was not sufficient, on February 23, 1982, Louis B. Hays wrote another memo to all ALJs, specifically telling them that they were bound by Social Security Rulings and were to ignore Finnegan even in "cases involving Court of Appeals for the Ninth Circuit." (Exhibit D)

This practice is clearly illegal. At least two circuit courts of appeals have struck a virtually identical practice of the National Labor Relations Board. See, for example, Ithaca College v. NLRB, 623 F.2d 244 (2d Cir. 1980); Allegheny General Hospital v. NLRB, 608 F.2d 965 (3d Cir. 1979). These cases hold that the agency is bound to follow the law of the circuit. Failure to do so results in the agency operating "outside the law." Allegheny General Hospital, 608 F.2d at 970.

SSA's illegal practice, just in the Finnegan case, resulted in the filing of additional litigation, all of which must be defended at government expense. In the state of Washington, a class of grandfathered SSI recipients who have been terminated have sued to enforce Finnegan. Siedlecki v. Schweiker, No. 81-6-R. (W.D. Wash.) It is likely that other such cases will be filed in the states within the jurisdiction of the Ninth Circuit. In addition to needless governmental expense, SSA's failure to follow Finnegan has resulted in the cessation of hundreds, perhaps thousands, of SSI grandfathered recipients who are clearly entitled to benefits and who have no other means of support.

We stress that the Finnegan case is just one example of this problem.* Steps must be taken to require SSA and the Secretary

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*For other examples, compare: Levings v. Califano, 604 F.2d 591 (8th Cir. 1979), with Social Security Ruling (SSR) 80-11c; Boyland v. Califano, CCH Unempl. Ins. Rptr. ¶ 16,912 (6th Cir. 1980), with

(footnote continued on page 13)

of HHS to act within the laws both as it is written by the Congress and interpreted by the courts.

C. SSA frequently issues order which are inconsistent with the statute and SSA's own regulations.

SSA often utilizes the Social Security Rulings (SSRs), Program Operations Manual System (POMS), and a variety of other informational documents, to establish rules which are inconsistent with the Social Security Act and Social Security's own regulations. In the context of the CDIs, the result has been that thousands of beneficiaries' cases are being illegally terminated, only to be later restored by the ALJs, who do follow the federal statute and regulations.

Examples of the problem reflect its enormity:

1. 20 C.F.R. §416.929 requires that consideration be given to a person's pain in assessing his/her disability. This is supported by numerous court

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(continuation of footnote from page 12)

SSR 81-1c; *Rasmussen v. Gardner*, 374 F.2d 589 (10th Cir. 1967) with SSR 68-48c. This list is by no means exhaustive. Even where SSA has not issued a ruling refusing to follow a court's order, it has frequently done just that, ignoring others similarly situated until another court requires it to address the class aspects of the issue. For example, the district court's failure to certify a class in *Wiesenfeld v. Secretary of Health, Education and Welfare*, 367 F.Supp. 981, 986-987 (D.N.J. 1973) (three-judge court), which invalidated a gender based classification in the Social Security Act, resulted in the need for additional litigation. First, the Secretary refused to provide relief to anyone but the named plaintiff until the Supreme Court issued its decision affirming the three judge court's ruling. 420 U.S. 636 (1975). Second, after that ruling, the Secretary applied the decision only prospectively to other individuals. At least two other suits were filed in order to obtain the benefits for the period prior to the Supreme Court's decision. See *Crumpler v. Califano*, 443 F.Supp. 342 (E.D. Va. 1978); *Hurvich v. Califano*, 457 F.Supp. 760 (N.D. Cal. 1978).

decisions. Yet, SSA deleted the instructions to consider pain from the POMS, which is followed by the state agencies, explaining that "deletion of this section reflects the appreciation that an improper emphasis on the role of pain is conveyed." Section 2205.

2. 20 C.F.R. §404.1545(a) requires that in assessing a person's residual functional capacity (RFC) to work, all impairments will be considered. With regard to mental impairments, 20 C.F.R. §404.1545(c) provides:

   > When we assess your impairment because of mental disorders, we consider factors such as your ability to understand, to carry out and remember instructions, and to respond appropriately to supervision, co-workers and work pressures in a work setting.

   Obviously, as the Secretary has recognized, these factors are critical in assessing the ability of the mentally disabled person to work. Yet, via an "informational digest", SSA eliminated consideration of mental impairments from the RFC evaluation. The result has been the wholesale termination of severely mentally disabled people from the rolls based upon findings that they have the residual functional capacity to work.

3. As noted in the earlier discussion on "non-acquiescence", SSA has refused to follow the Finnegan ruling that there must be evidence of medical improvement or a showing that the original decision of eligibility was clearly erroneous before a disabled person grandfathered into

the SSI program may be terminated. Using a Social Security Ruling, SSA has ordered the ALJs to ignore Finnegan. SSR-82-10c. It should be noted that the Rulings are not statutorily recognized but are, instead, a creation of the Secretary which he has, by virtue of one regulation, made binding upon ALJs while avoiding public notice and comment. 20 C.F.R. §442.408. Most recently, SSA has begun to issue a series of Social Security Rulings which address matters generally contained in SSA's regulations. To the extent that the SSRs differ from the regulations, they represent SSA's attempt to control the decision-making of administrative law judges without amending the federal regulations. Because SSA has not provided for public notice and comment as required by the Administrative Procedures Act, 5 U.S.C. §553 et seq., SSA's actions violate the APA.*

It is critical that the current system of dual rules be changed. However, any change should assure that all binding rules be subject to public notice and comment. Under a provision of H.R. 6181 (Section 7) passed by the House Ways and Means Committee, the Secretary would be required to assure that all levels of review follow the same standards. However, there is no mention of public notice and comment. The Commissioner has indicated that he will utilize the SSRs to create such rules. The bill would permit him to utilize even the POMS. The provision should not be enacted. It is critical that the disability determination process and the standards utilized therein be accessible to the public and subject to public comment. The only binding rules should be those which are properly promulgated in accordance with the Administrative Procedure Act. SSA's unauthorized practice of "non-acquiescing" in judicial decisions it disagrees with has effectively insulated it from fully complying with various court rulings, despite SSA's failure to appeal the decisions with which it disagreed. The Social Security Rulings, SSA's vehicle for "non-acquiescing," should not be accorded the weight suggested by the proposed provision. Rather, Congress should examine SSA's policy of "non-acquiescence" and consider its appropriateness in the overall administrative review scheme. Similarly, changes in the POMS are not issued for public comment. The effect of Section 7 will be to encourage SSA to avoid the regulatory process, just amending the POMS. As mentioned earlier, SSA already tends to issue POMS sections long before even proposed regulations are issued. This practice should be discouraged rather than encouraged. Further, the public comment process is extremely important. Often it is the only means available to claimants and their representatives to express their concerns. Finally, access to the POMS is limited to SSA offices, unlike the Code of Federal Regulations, rendering it more difficult for claimants and their representatives to remain up-to-date on its contents.

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*HHS recently proposed to withdraw from compliance with the notice and comment requirements of the Administrative Procedure Act. 47 Fed. Reg. 26860 (June 22, 1982). SSA's policies and practices provide an excellent example of a portion of HHS which for some time has chosen to ignore the APA. As such, it reflects well the likely result if HHS implements its proposal: total confusion between levels of review; imposition of standards which violate the statutory authorization and whatever regulations the agency may choose to promulgate.

D. Consultative examinations purchased by SSA are generally inadequate.

The federal government paid approximately $137,400,000 for consultative examinations in 1981.* It is therefore reasonable to assume that SSA should be expecting to get something useful for its money. Further, as the consultative examiner's report is often the only document which supports the arbitrary and incorrect terminations in the CDIs, it is critical to the disabled individual that they be performed properly and that reports accurately and completely describe their medical condition.

The Oversight and Social Security Subcommittees of the House Ways and Means Committee have held two hearings specifically addressing the problems created by "volume provider" consultative physicians, those who do a substantial amount of business with state disability units.** While the problems are exacerbated by the bulk nature of their business, the underlying theme of the need for effective regulation and monitoring by SSA exists regardless of the number of referrals.

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*Statement of Sandy Crank, Associate Commissioner for Operational Policy and Procedures, Social Security Administration, September 18, 1981, House Ways and Means Committee, Serial 97-27, page 12.

**In many states, the volume or bulk providers are churning out report after report, denying disabled individuals the benefits to which they are entitled. In Tennessee, for example, the volume provider denies disability at a higher rate than the average. At the September 18, 1981 hearing, Herbert L. Brown, Director, Disability Determination Section, Tennessee, stated that, in a sample review, Thurman and Thurman denied 82.5% while the state average was 73%. "Volume Providers of Medical Examinations for Social Security Disability Programs," Serial 97-27, page 92.

Given the emphasis on time and the incredible backlog created by the CDIs (as well as the acceleration of the CDI process), it is not at all surprising that the states place a premium upon a physician's ability to provide reports in the shortest time possible. Two aspects of this are particularly disturbing. First, time appears to take priority over all, or almost all, other relevant considerations in making the referrals to consultative physicians. Second, the volume providers, doing all or almost all of their buisness with state DDS units, recognize this need and, with their word processing equipment and often questionable practices, are able to capitalize upon it, to the detriment of disabled individuals.

The states' preoccupation with timeliness is reflected in the material which SSA provided to the Oversight and Social Security Subcommittees of the Ways and Means Committee set forth at Ways and Means Committee Print, Serial 97-27, pages 25-34. Timeliness of reporting is often cited as a basis for identifying a referral while no reference is made to identifying the physician(s) whose specialty renders him/her in the best position to properly assess the claimant's condition.

In some areas of the country, the administrative law judges simply ignore the consultative reports because their experience with the particular provider(s) has taught them that their reports are useless and unreliable. Given the current abuses of some consultative physicians, this is as it should be. However, it is critical that the cost implications be recognized. Because SSA has failed to regulate consultative physicians, it is throwing money away just so that it can assure that there is a piece of paper in the file. If the reports are so useless as to be ignored, they should not be purchased. It is critical that SSA be required to issue regulations which set forth minimum requirements for consultative physicians. Factors which have been suggested include:

1) a limit on the number of examinations which may be scheduled per hour and per day;
2) minimum competency requirements for technicians, aides and paramedics who assist in performing any portion of the exams, including interviews for the claimant's history;
3) periodic checks on the equipment used in consultative exams;
4) the consultative physician must personally author and sign the report and the physical capacities evaluation;
5) the state unit consider paying for a consultative exam performed by the claimant's treating physician before considering a referral to a non-treating physician;
6) the state disability determination unit establish contacts with community health clinics to assure that more consultative exams are performed locally instead of by volume providers;
7) written documentation as to how much time the consultative physician spent examining the claimant;
8) written documentation that the laboratory tests and x-rays were actually performed;
9) the consultative physician should be required to have

familiarized himself/herself with the various test results and to have personally read all x-rays prior to completion of the report; and

10) creation of a mechanism for assuring that claimants' complaints and concerns regarding consultative physicians are investigated and resolved.

E. SSA is creating barriers to obtaining a full hearing on appeal.

1. Accessibility of hearings.

Briefly, SSA is making it tougher for appellants to appear at hearings before ALJs. First, the Office of Hearings and Appeals has limited the ability of ALJs to travel to satellite locations. Unless the location is over 75 miles from the appeals office, the claimant must travel to the appeals office. See January 7, 1982 memo from Louis B. Hays, page 2-3, attached as "Exhibit B." This is true despite the fact that there may be more than one large concentration of population in the 75 mile area, thus creating significant hardships for large numbers of people. For example, OHA no longer holds hearings in Colorado Springs. Appellants must all travel to Denver. In Florida, SSA is holding hearings at a location in a city within 75 miles of the hearing office but refuses to permit residents of that city to appear there because they live within 75 miles of the main office.

Needless to say, there is no statutory or regulatory authority for the 75 mile rule. It is an arbitrary limit which far exceeds reasonable expectations of the ability of severely disabled people to travel. But, OHA may force some appellants to travel even further. The Hays memo indicates that OHA "will also encourage giving claimants the option to travel to the hearing office for their hearing, even if the distance is more than 75 miles." Id. page 3.

2. The adversarial experiment.

SSA will also soon announce that it has decided to implement the "government representative experiment," also known as "the adversarial experiment." This proposal was originally floated in 1980, 45 Fed. Reg. 2345 (January 11, 1980), and, after substantial Congressional and public outcry, was later withdrawn by Secretary Harris. 45 Fed. Reg. 47162 (July 14, 1980). On February 18, 1982 this Administration reinstated the proposal without republishing its contents and, in its prefatory comments, discouraged the public from filing comments. 47 Fed. Reg. 7261. Under the proposal, SSA will be represented at hearings before administrative law judges at five locations (believed to be Baltimore, Maryland; Kingsport, Tennessee; Columbia, South Carolina; Pasadena, California; and Brentwood, Missouri).

When this proposal is finalized, the disabled CDI appellant will face an adversarial process in which the SSA representative will control the collection of evidence, regardless of whether the disabled individual is represented.*

This is a uniquely inappropriate expenditure of SSA's resources, at great expense to the disabled. As SSA has inappropriately encouraged and, in many cases, demanded termination of the benefits of disabled individuals who are clearly eligible for those benefits, it is perhaps not surprising that SSA would seek to make it even more difficult for the disabled to obtain a full and fair hearing of the evidence in their cases.

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*While the proposed regulations would bar the SSA representative from attending a hearing where the appellant was not represented, they still require the SSA representative to compile the evidence. The unrepresented individual is therefore doubly disadvantaged: not only is he/she not represented but he/she is also unaware that an adversary, supporting the agency's position of denial, prepared the case file.

3. Proposal to close the evidentiary appeal before the ALJ level

Unfortunately, Congress may soon incorporate other procedural barriers for the disabled, this time at the reconsideration level. In H.R. 6181, the evidentiary record will be closed after a hearing is held at the reconsideration level. As reported at the Ways and Means Committee mark-up, either the bill or the report will indicate that the state reconsideration level hearings must be as accessible as ALJ hearings. In a time when SSA is rendering ALJ hearings increasingly inaccessible, it will be disastrous for that scheme to be looked to as the standard for the state level.

F. Termination of benefits without evidence of medical improvement

SSA is terminating the benefits of individuals who are no better than they were on the day that benefits were awarded and, in fact, are often in much worse condition. SSA's method for pulling the rug out from under disabled beneficiaries is very simple: if you can't prove that they're not disabled under the standards in effect when they became disabled, change the rules so that you can tell the American public and the Congress that the rolls are full of non-disabled people whose benefits must be terminated. Then, terminate their benefits.

This approach is not only unconscionable, it violates the intent of the Social Security Act. Benefits are to be terminated when the disability "ceases." 42 U.S.C. §423(a)(1).* The general understanding** of this term is "stops" or "ends," not "when the federal government changes the rules so that your medical condition no longer qualifies you for benefits." Surely is is reasonable to expect that Congress intended the ordinary meaning of the term.

Numerous courts have required SSA either (1) to establish that there has been medical improvement or that the original decision was clearly erroneous or (2) to rebut the presumption that the person is still disabled. See, for example, Patti v. Schweiker, 669 F.2d 582 (9th Cir. 1982); Finnegan v. Schweiker, 641 F.2d 1340 (9th Cir. 1981); Miranda v. Secretary of HEW, 514 F.2d 966 (1st Cir. 1975); Shaw v. Schweiker, 536 F.Supp. 79 (E.D. Pa. 1982); Musgrove v. Schweiker, ___F.Supp.___ (E.D. Pa. June 18, 1982). Yet, SSA persists in ignoring the courts and terminating disabled beneficiaries.

Until 1976 SSA utilized the medical improvement standard. Then, without amending its regulations, it changed the standard. It was not until 1979 that SSA amended the regulation.

Implementation of the medical improvement standard is fair, compassionate, and logical. It will permit the disabled to reasonably rely upon their government where their condition does not improve or worsens. It will also substantially reduce the appellate workload for SSA: if SSA treats the recipient fairly in the first instance, expensive appeals will not be needed.

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*"...For purposes of the preceding sentence, the termination month for any individual shall be the third month following the month in which his disability ceases; ..." 42 U.S.C. §423(a)(1).

**Webster's defines "ceases" as: "to bring to an end : Terminate (the dying man soon ceased to breathe)... : to come to an end...to bring an activity or action to an end : discontinue...to die out : become extinct. Webster's New Collegiate Dictionary, page 176 (1980).

Finally, the standard is attractive because it is easily understood by state disability personnel and, most importantly, the treating physician. The treating physician is in the best position to assess changes in the recipient's medical condition. Yet, he or she is the least able or interested in trying to apply ever-changing rules to each individual's case.

G. Role of the medical advisers at the state level

Within every state disability unit are one or more "medical advisers", physicians who review the evidence in the claims file and make an assessment regarding the person's "residual functional capacity" to work. While this person never sees, much less examines, the claimant/beneficiary, it is his/her opinion regarding how long the person can walk, stand and sit, how much she can carry, etc., which is the basis for the state adjudicator's assessment of whether the person can perform "sedentary", "light", or "heavy" work and, thus, which of the medical-vocational charts will be applied.

Courts have generally been wary of relying upon the opinions of the non-examining medical adviser where his/her opinion conflicts with other evidence. See, for example, Johnson v. Harris, CCH Unempl. Ins. Rptr. ¶ 16,783 (5th Cir. 1980) [The report of a non-examining physician does not constitute substantial evidence.]; Lang v. Harris, 505 F.Supp. 43, 45 (W.D. Mo. 1980) [". . . while the opinions by nonexamining physicians may constitute substantial evidence for consideration, they deserve little weight in the overall evaluation of disability."]; Moody v. Califano, CCH Unemp. Ins. Rptr. ¶ 16,737 (N.D. Ala. 1979) ["While not conclusive, the opinion of a non-examining medical adviser may be considered by the Secretary in his decision to deny benefits. (cite omitted) However, the report of a non-examining physician may only be considered to the extent that it does not differ from the medical reports of an examining physician."]; McClanahan v. Harris, CCH Unempl. Ins. Rptr. ¶ 17,362 (S.D. Ohio 1980) [It is not the medical adviser's role to "serve the purpose of second-guessing the doctors responsible for the plaintiff's welfare..."] Toner v. Secretary of HEW, CCH Unempl. Ins. Rptr. ¶ 17,338 (D. Mass. 1980) [from the "excerpts of proceedings", included as part of the court's opinion: "I do not consider the medical checklist [used by a reviewing medical officer] - physicians who have simply said she has not proved enough, I do not consider that their opinions are the equivalent of an opinion that she is not disabled ... They are just negative conclusions, and do not amount to substantial evidence in comparison with the reports of her attending physicians."]

Unfortunately, SSA and the states rely far too heavily on the opinions of these non-examining advisers, often to the total exclusion of treating physicians and, in some cases, consultative examiners. Congress should take steps to assure that the weight given to these opinions is minimized at least where they conflict with the opinions of examining physicians.

CONCLUSION

Disabled Social Security and SSI recipients have been stripped of all predictability and security in their lives by SSA's abusive approach to the continuing disability investigations, as discussed in this statement. It is incumbent upon the Congress to take the steps necessary to change the message at SSA and to restore the predictability and security so badly needed by the disabled in this country.

Again, I thank Senator Heinz for providing me with this opportunity to comment.

Analyst

MORANDUM

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
SOCIAL SECURITY ADMINISTRATION

: Chief and Deputy Chief Administrative Law
Judges
Regional Chief Administrative Law Judges
All Administrative Law Judges

DI-12
DATE: MAY 07 1981

REFER TO:
SGP-2
300(81)

ROM : Andrew J. Young
Associate Commissioner
Office of Hearings and Appeals

RECEIVED
MAY 13 1981
OHA PASADENA

JBJECT: Accelerated CDI Program - Impact on Office of Hearings and Appeals - INFORMATION

As you know, the Social Security Disability Amendments of 1980 (P.L. 96-265) provide for the review, effective January 1982, of all Title II disability beneficiaries at least once every 3 years unless their disabilities have been declared permanent. Beneficiaries with permanent disabilities must be reviewed less often, i.e., every 5 to 7 years. This review was mandated by statute as a result of Congressional concern about the lack of a consistent, large scale effort by SSA to reexamine the cases of individuals who have been on the disability rolls for many years.

Studies completed by the Social Security Administration and others over the last two years - and most notably the recent General Accounting Office study - suggest that there may be significant numbers of people on the disability rolls who do not currently meet the requirements of the law for continued entitlement. In view of these findings, a major policy decision has been made to review as many cases as possible on the SSA rolls. The Administration is not waiting for the periodic review provisions of the new law to become effective and, indeed, has already begun this review in conjunction with the state Disability Determination Services.

I have been asked by the Commissioner to express to you his concerns about the findings of the recent studies and the seriousness with which he views the SSA effort to thoroughly review those cases of individuals now on the rolls to determine whether they still fully meet all requirements for entitlement. I share the Commissioner's concerns.

Impact of Effort on OHA

It is expected, if the GAO findings are reasonably reliable, that the DDSs will determine, at initial and/or reconsideration levels, that cessation of benefits is warranted for a large number of disability beneficiaries. It is to be further expected that such individuals will avail themselves of their statutory rights to challenge such cessations by requesting hearings before our administrative law judges, probably in ratios at least equivalent to that prevailing for initial benefit denials (now running at over 70 percent).

A, p. 1

We do not know the exact volume of the hearing workload which will result from cessation determinations made during the accelerated CDI initiative, but it is one which must be handled. The new regulatory standard for assessing such cases, as you know, is no longer whether there is demonstrated medical improvement but rather whether the beneficiary, on the basis of current evidence, is disabled or not under the adjudicative standards that govern disability adjudication (see SSR 81-6, January 1981).

This is a serious effort designed to assure, in the traditions of prudent and sound public administration, that benefits are being paid only to those individuals fully and legally entitled to them. Since the accelerated review schedule must first pass through DDS processing, we anticipate that the initial impact from the CDI initiatives will likely first be felt in OHA in August or September of 1981 with the full impact not expected felt until FY 82.

A, p. 2

DEPARTMENT OF HEALTH & HUMAN SERVICES

RECEIVED FEB 1 1982

Memorandum

Refer to SGA

Date JAN 7 1982

From Associate Commissioner
Office of Hearings and Appeals

Subject ALJ Policy Council Meeting

To All Administrative Law Judges

I would like to share with you a summary of the topics and discussion at the meeting of the ALJ Policy Council held in Arlington, Virginia on December 2 and 3, 1981. The meeting was attended by Kathleen R. Dacey (Boston), Irwin Bernstein (Jamaica), Moses Thompson (Montgomery), Gordon L. Sroufe, (Columbus), John M. Slater (Tulsa), Edwin W. Ganter (Brentwood), Paul Smelkinson (Phoenix), Robert C. Wetherhold (Seattle), and Charles L. Leonard (RCALJ, Region II). The ALJ Association was represented by its President, Paul Rosenthal.

Adjudicatory Policy

We are continuing to work with the other SSA components to develop uniformity in adjudicatory policies and standards for all elements of SSA. Our goal is to ensure that all levels of adjudication are following a single set of policies and guidelines, as determined by the Secretary. We had extensive discussions during the meeting concerning how these policies are developed and the manner in which OHA is participating in the process. Rhoda Greenberg of the Office of Disability Programs and Frank Dell'Acqua, Deputy Assistant General Counsel, Social Security Division, participated during this portion of the meeting. Much of the discussion centered on the proposal to give binding policy effect to disability adjudication guidelines in the POMS. As the result of a suggestion by Paul Rosenthal, we are considering as an alternative the publication of one or more Social Security Rulings to establish a single set of adjudicatory standards for all levels to follow.

In general, there are four major efforts underway in the area of developing more uniform adjudicative standards:

1) We are working with ODP to identify the specific portions of the POMS that are relevant to the adjudicative standards.

2) Program Policy Statements are being developed for a number of major topics, including residual functional capacity and transferability of skills.

3) We are attempting to identify additional case type disability rulings for publication as Social Security Rulings to provide additional precedential guidance to adjudicators.

4) We are promoting a more systematic review of court decisions to better identify candidate cases for appeal. As part of the discussion on this subject, Frank Dell'Acqua stressed the point that the federal courts do not run SSA's programs, and that ALJs are responsible for applying the Secretary's policies and guidelines regardless of court decisions below the level of the Supreme Court. Court decisions can result in the changing of policies, but it is not the role of ALJs to independently institute those changes.

Travel Allocation Cutback

Under the continuing resolution in effect at the time of the Policy Council meeting, OHA was operating under a 50 percent cut in travel funds in comparison to last year. Although we do not yet know how much travel money will be available for the remainder of the fiscal year, we definitely will have much less than we need and expected. We have no choice but to re-examine the way in which we have been doing business in regard to travel in view of this cutback.

We had considerable discussion about the issue of hearing assistant travel. The biggest reason for the change in policies on hearing assistant travel is that more than $1 Million would be spent on this type of travel this year under normal practices. We have therefore placed a general restriction on hearing assistant travel, with exceptions only being approved on an individual basis by the CALJ. We are, however, taking steps to continue to provide assistance to ALJs in conducting hearings while on travel. The availability of When Actually Employed (WAE) employees is being expanded throughout the country, and we are seeking temporary assistance from the district and branch offices located near hearing sites.

We are also re-examining the policies and procedures on claimant travel. During 1981, 51 percent of travel by ALJs occurred within 75 miles of the ALJ's office. Although it may be difficult to actually change the existing policies to extend the travel radius, there was general agreement from the Policy Council that OHA should more fully enforce the present policy. We will also encourage giving claimants the option to travel to the hearing office for their hearing, even if the distance is more than 75 miles.

Government Representative Experiment

The Government Representative experiment is being delayed at least until March 1982 so that a Federal Register Notice can be issued. Four offices will participate in the experiment. The goal of the experiment will be to evaluate the effect of a government representative on productivity and quality. Procedures for the role of government representatives are still being developed.

Blankenship

The government has filed a motion in the Blankenship case to obtain relief from the court-ordered time limits on the basis of drastically changed circumstances. We are arguing that the rapidly increasing workloads have changed the context of the original judgement, and have made the notion of time frame regulations and court-ordered time limits untenable. As a substitute, we are proposing to publish annually in the Federal Register a non-binding average processing time goal. If we are successful, we will not have to do special tracking of individual cases.

Attorney Fees

Proposed legislation is pending with OMB to eliminate SSA's involvement in attorney fee processing and approval. The Office of General Counsel is also analyzing the potential for regulatory change in this area. The Policy Council recognized that there are alternative remedies available for responding to problems that arise with certain attorneys aside from the fee authorization provisions.

Word Processing

The procurement of "state-of-the-art" word processing equipment for all hearing offices is underway. Installation will be on a phased basis beginning in Summer 1982. The equipment will include video display terminals and keyboards, and the printers will be capable of producing at twice the speed of our present equipment.

B, p.3

Minimum Number of Cases Per Hearing Trip

A proposed policy was recently circulated to the field for comment regarding the establishment of the requirement for a minimum of 25 cases per hearing trip. Many of the responses on this proposal failed to recognize that it includes ample leeway for ALJICs to grant exceptions as circumstances warrant. This policy has been developed in response to the Inspector General's criticism of abuses within OHA and is in no way linked to any attempt to establish productivity quotas.

Bellmon Review

The Bellmon "own-motion" review started on October 1, with 65 ALJs selected for review. Those ALJs who were selected have either the highest individual allowance rates or come from hearing offices with the highest overall allowance rates. The review covers 50 percent of the ALJs' allowance decisions on Title II and concurrent cases. For sample selection purposes, 100 percent of those workloads are being sent to Central Office. Sixteen hearings and appeals analysts are assigned to the review and are making recommendations for own motion to two Appeals Council members. There is an own motion recommendation rate of approximately 25 percent. Those cases on which the Appeals Council takes own motion are either reversed on the record or remanded to the ALJ. The Appeals Council is sending detailed descriptions of deficiencies to the ALJs for all own motion cases. Approximately seven and one-half percent of all ALJ allowances are now being reviewed. The number of cases will be doubled by April 1982 as additional analysts become available to participate in the review. Once the larger case review capability is achieved, a random sample of all ALJ allowance decisions will be added to the review.

A second aspect of the Bellmon amendment is the requirement for a report to the Congress concerning a study of the problems and differences in the adjudicative standards and approaches used at the various levels in the decisional process. The report, which is now being completed, concludes that there are major differences between OHA and the DDSs and between ALJs and the Appeals Council within OHA.

Quality Control System

We are revamping OHA's Quality Control System to develop a mechanism to provide more direct and specific feedback to the field. I am concerned that the information generated by the present system is so general as to be of very limited utility. We are attempting to design a new procedure that will provide much better information to the field.

B, p. 4.

The Policy Council generally agreed that an improved quality control mechanism of this nature is needed to allow better identification of training needs and to accentuate areas where policy clarification is required.

Reconfiguration

The original reconfiguration experiment involving six offices has led to expansion to approximately 30 offices in 1982. We will give priority in allocating resources, both in personnel and equipment, to these offices. Central Office and the Regional Offices will be working closely with all of the offices to assure smooth implementation. We are very mindful of the potential for short-term negative effects on productivity during implementation of the new processes, as pointed out by the Policy Council. However, we cannot ignore the significant potential long-term gains. In addition to the full reconfiguration of these 30 offices, we will also be encouraging other forms of innovative work processing.

Staff Attorneys

There continues to be a high degree of interest in finding a method by which staff attorneys can qualify as ALJs. In view of our need to hire a large number of additional ALJs this year, we have to explore every opportunity to find high-quality candidates. Our staff attorneys could provide an excellent pool of such individuals.

The Policy Council agreed that staff attorneys should not be barred from qualifying for the ALJ register. The basic issue is to find a method to fulfill the requirement that candidates already working for the government must have one year of experience at the GS-14 level. It appears that the best method to address this problem would be to have OPM give approval for the experience of a GS-13 staff attorney as fulfilling the requirement for time in grade as a GS-14. OHA could then pursue the approval of supervisory GS-13 staff attorney positions in the Regional Offices and Hearing Offices. We are not presently pursuing any other alternatives, such as establishing GS-14 hearing examiners.

Field Training Initiatives

We have established a Field Training Initiative Staff in Central Office under the direction of Irwin Friedenberg of the Washington, D.C., Hearing Office. Irv is working with Tom Capshaw to offer five continuing education seminars for ALJs beginning in April 1982. Each of these seminars will include a one and one-half day ALJ refresher training session in addition to the time utilized by the Continuing Judicial Education Committee. Additional training for all hearing office support staff is also being developed. OHA has allocated almost six times as much money for training in 1982 in comparison to last year.

Once again, the Policy Council meeting provided a frank and open exchange of ideas on the important issues facing OHA. The advice and opinions expressed by all of the participants were extremely valuable and resulted in several significant policy decisions.

Louis B. Hays

Louis B. Hays

cc: RCALJs
OHA Executive Staff

HEALTH & HUMAN SERVICES

Memoran

cc: DLS
OPI
OSC
OAC
DA

Date SEP 14 1981

From: Associate Commissioner
for Operational Policy and Procedures

Subject: Federal Title XVI Litigation--*Terry Finnegan* v. *Matthews* (U.S. Court of Appeals, Ninth Circuit, 641 F. 2d 1340, April 16, 1981)--INFORMATION

To: Donald A. Gonya
Assistant General Counsel

9-24 DF

ISSUE

This is in response to your request for my recommendation on whether we should seek an appeal to the Supreme Court in *Finnegan*. I believe that we should not petition for a writ of certiorari in this case, but, instead, should publish a ruling of nonacquiescence. The issue in *Finnegan* is whether the Social Security Administration (SSA), when attempting to remove a grandfathered Supplemental Security Income (SSI) disability recipient from the rolls, must show that there has been "a material improvement in his medical condition" or that there was "a clear and specific error" made by the State in its original determination of disability under the former State program.

BACKGROUND

The plaintiff, Terry Finnegan, who had been receiving State disability welfare payments since 1972, was grandfathered into the SSI program in 1974. Following a continuing disability investigation, he was informed that SSI payments would cease because he was no longer disabled under either the Federal SSI program or the Washington State disability program which was in effect prior to January 1, 1974 (the effective date of the SSI program). SSA's decision to terminate *Finnegan* was affirmed by the U.S. District Court for the Eastern District of Washington. On April 16, 1981, the U.S. Court of Appeals for the Ninth Circuit reversed the decision of the district court and thereby reversed SSA (see tab A). In reversing SSA, the Court of Appeals found that the termination of Finnegan's benefits was improper because there was "no material improvement in Finnegan's medical condition or clear and specific error in the prior State proceedings."
On June 25, 1981, the Court of Appeals denied SSA's request for a rehearing in *Finnegan*.

Section 1614(a)(3)(E) of the Social Security Act is the "grandfather" clause which provides for the continued payment of SSI to a converted individual who "is permanently and totally disabled as defined under a State plan . . . so long as he is continuously disabled as so defined." Section 1614(a)(3)(E) also limits eligibility for conversion to those individuals

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C, p.1

who in December 1973 were receiving aid for their total disability under a State plan approved under title XIV or XVI, as in effect for October 1972. Individuals eligible for conversion must also have received aid for at least one month prior to July 1973. These limitations to the grandfather clause were added as a "rollback" amendment to prevent States from transferring their welfare recipients onto the disability rolls in anticipation of the Federal takeover.

DISCUSSION

SSA interprets section 1614(a)(3)(E) to mean that individuals who satisfy its criteria are grandfathered into the SSI program and are thereby protected from termination of SSI benefits so long as they continue to meet the Federal or the former State plan definition of disability. When a continuing disability investigation is conducted to determine whether a grandfathered SSI recipient is still disabled as defined by the State plan, State statutes and regulations are available and used by disability examiners and Administrative Law Judges (ALJs) in adjudicating cases.

In Finnegan, the Court of Appeals rejected SSA's interpretation. According to the Ninth Circuit:

> "An ALJ's inquiry must . . . focus on whether a clear and specific error had been committed during the previous State determination of eligibility and on whether the recipient's medical condition has materially improved. Absent a finding of clear and specific error in the earlier determination a recipient must logically have been 'disabled under a State plan;' absent a finding of subsequent material medical improvement a recipient must logically still be disabled 'as so defined.'"

In essence, the Finnegan court's order means that ALJs should not rely on their own interpretations of the prior State plans, but rather that they should weigh the current evidence against the State's initial disability determination to decide whether there was "specific error" or whether the recipient's "medical condition has materially improved."

SSA would face problems in complying with the court's order because in many conversion cases the evidence with which convertees were initially allowed is either incomplete, unavailable, or no longer in existence. In the case of Finnegan, it would be possible to comply with the court's directive because the record contains a copy of the State's initial disability determination in 1972, as well as pertinent medical evidence for that period. In many conversion cases, however, complete documentation regarding the State's initial finding of disability is unavailable. It would be difficult in those cases to show either improvement or error.

C, P.

While we strongly disagree with the court's rationale and would face major problems in implementing the court's order generally, there are significant weaknesses in the *Finnegan* case. Mistakes were made in the legal defense of this case before the Court of Appeals. It seems that the U.S. Attorney's office defended this case without the advice of the Department of Health and Human Services' legal counsel and misinformed the court about SSA's position with regard to grandfathered SSI recipients.

In addition, there has been no improvement in Finnegan's medical condition since the original State allowance and according to our review of the medical evidence in file, it is questionable whether Finnegan is in fact not disabled at this time. Since the facts indicate that the State determination was one of judgment, and since we *know* that Finnegan has not improved, we believe that the Supreme Court might not think it appropriate for SSA to substitute its judgment for that of the original adjudicator.

RECOMMENDATION

I recommend that certiorari to the Supreme Court not be sought in *Finnegan*. Although the court's order is based on a faulty understanding of the continuing disability process, the standards applied by SSA and the practical problems in complying with the more restrictive standard erected in *Finnegan*, we believe that the factual situation in *Finnegan* makes it inappropriate for review of these issues by the Supreme Court.

If the Solicitor General decides not to seek certiorari, we believe it is critical that SSA publish a ruling of nonacquiescence in order to limit the holding of the Ninth Circuit to Mr. Finnegan. With a nonacquiescence ruling, we can attempt to argue this issue again before the courts in a case in which the plaintiff is clearly not disabled, where the State disability determination is in fact not available and where the case can be prepared properly without the legal flaws found in *Finnegan*. The Office of Hearings and Appeals agrees with this course of action.

/s/ Sandy Crank

Sandy Crank

Attachment:
Tab A - Circuit Court Decision

cc:
Office of Disability Programs
Office of Hearings and Appeals
Office of Regulations (Rulings)

DEPARTMENT OF HEALTH & HUMAN SERVICES

Refer to: SGP-2

Memorandum

22(82)
CL-19

Date: FEB 23 1982

From: Associate Commissioner
Office of Hearings and Appeals

Subject: Ruling of Non-Acquiescence-Continuance or Cessation of Grandfatheree's Disability - INFORMATION

To: All RCALJs
All ALJICs
All ALJs

On April 16, 1981 the United States Court of Appeals for the Ninth Circuit issued a decision holding that Supplemental Security Income (SSI) benefits based on disability to a claimant who had been converted from the State welfare rolls to the Federal SSI program in January 1974 (grandfatherees) could not be terminated unless SSA showed that there was either a material improvement in the claimant's medical condition or a clear and specific error in the prior State determination.

I want to draw your attention to Social Security Ruling SSR 82-10c in the January 1982 quarterly Rulings publication, indicating the Social Security Administration's non-acquiescence in the Court's decision. Under SSA policy, it is not necessary to show that there has been improvement in the claimant's condition or any error in the prior State determination for benefits to be ceased. It is SSA's position that a grandfatheree's SSI benefits based on disability may be ceased when the claimant's disability, as shown by the current medical or other evidence, does not meet the criteria of the appropriate State plan or the Federal criteria—i.e., the impairment is such that the claimant is able to engage in substantial gainful activity (20 CFR 416.994).

Although the ruling addresses only criteria for ceasing disability for a grandfatheree, you should be aware that the criteria for ceasing benefits based on disability also apply where the claimant is a title II or SSI non-grandfatheree beneficiary. This basic policy is reflected in SSR 81-6 (January 1981, p.27).

Social Security Ruling SSR 82-10c is binding on all components of SSA including administrative law judges and the Appeals Council (20 CFR 422.408). SSA's policy must be followed in cases involving the issue of cessation of disability, including cases involving claimants who reside within the jurisdiction of the United States Court of Appeals for the Ninth Circuit.

Louis B. Hays

Louis B. Hays

cc:
Office of Appeals Operations
Co-Deputy Chairperson, Appeals Council

TESTIMONY

OF

SIEGLINDE SHAPIRO,

EXECUTIVE DIRECTOR

OF THE

PENNSYLVANIA COALITION OF CITIZENS WITH DISABILITIES

AT THE

DISABILITY OVERSIGHT HEARING

BEFORE THE

COMMITTEE OF FINANCE

UNITED STATES SENATE

AUGUST 18, 1982

Senators Dole and Long and Members of the Committee:

I.

INTRODUCTION

I am Sieglinde Shapiro, Executive Director of the Pennsylvania Coalition of Citizens With Disabilities representing the interests of over 250,000 Pennsylvanians currently receiving Social Security Disability Insurance or SSI disability. We are a statewide coalition advocating the rights of the physically and mentally disabled and including such constitutent groups as the Pennsylvania Association of Retarded Citizens, Disabled In Action In Action of Pennsylvania, Developmental Disability Advocacy Network, United Cerebral Palsy Association of Philadelphia, Open Doors for the Handicapped, etc.

We wish to thank this Committee, especially Senator Dole for scheduling this important hearing and for Committee members, Senators Heinz, Durenberger and Moynihan who have already taken to their credit initiatives to introduce excellent remedial legislation to respond to what we believe is the greatest threat to the legitimate entitlement to disability benefits by truly disabled people throughout the nation.

Since March, 1981 almost 200,000 beneficiaries have been terminated yet current SSA appeal statistics show that 67% of those appealing are getting these cessations reversed, additionally others are getting terminations reversed on appeal later. Of the cases we and our attorneys see across Pennsylvania, we would estimate that over 90% of these terminations are clearly wrong decisions. We think this Committee would agree with us if you saw the innocent victims of these disability reviews -- people with obvious severe psychoses, some of whom have been hospitalized in a mental institution at the time Social Security is saying they are not disabled, or with cancer having eaten away half their face or an entire limb, or with heart disease or arthritis so severe they could not walk from the door of this hearing room to this table without intense pain.

There is a true crisis going on across the nation quite unintended, we believe, from what Congress sought in the 1980 amendments which called for accelerated reviews of practically all cases within but a three year period.

II.

SUMMARY OF REFORMS NEEDED

1. To prevent more, needless suffering, including the very loss of life from suicides, a temporary and limited moratorium is need along the lines of that proposed in S.2730 by Sens. Heinz, Chiles Durenberger, Hawkins and Specter. This would still allow review of ""diaried cases" of probable medical improvement (numbering almost 200,000 a year) and cases where actual substantial gainful employment

exists. A moratorium is the only humane and commonsense step to be taken immediately to allow for more systemic improvements to be made in a system that is directly causing pain and hardship, not ameliorating it.

2. Because most people appealing succeed at the ALJ hearing level, Title II benefits should continue on appeal at least to this level. This procedure exists currently and automatically with SSI disability appeals, where no abuse has ever been reported. Continuation of benefits is the only fair way to prevent suffering during the months of delay before the hearing.

3. Social Security should be required to show that someone whom they themselves determined to be disabled has substantially medically improved before being terminated. This is a common sense and equitable idea which in fact was SSA policy before 1968, and, in our view, has always been the intent of Congress in the Act. Certainly there is no logical and fair basis to terminate someone who is in the same or even worse condition now than he or she was in when found eligible by Social Security under the most rigorous disability tests.

4. Social Security should be required to obtain all relevant treating physician medical evidence before any cessation and afford it the great weight it should have in evaluating a disability.

5. If so-called uniform eligibility rules and criteria are established, they should explicitly be under the publication and comment protections of the Administrative Procedure Act.

6. Pain, which shockingly was excised out of Social Security's Program Operations Manual as not relevant to disability determinations, should be a factor required by statute to be utilized for disability determinations.

III.

SUMMARY OF CAUSES OF THE CRISIS

The prime causes of this cessation scandal are the unprecedented combining of three factors:

First is the impossible volume of cases being pressed upon state DD agencies, currently at 30,000 new reviews a month to increase in FY 83 when over 800,000 cases will be reviewed. Pennsylvania already has almost a 8 month backlock just in FY 82.

Second, are long-standing systemic weaknesses and failings in the federal and state disability processes, ignored for years by Congress and SSA, and now suddenly painfully visible as hundreds of thousands fall victim to these long ignored administrative failings; and

Third, is an undeniable effort by the current SSA administrators to save money on the backs of the disabled by changing standards of determining disability, accomplished quite secretly without Congressional sanction nor with notice and comment rights offered to the public to scrutinize what in essence has been agency sub rosa amendment of the Social Security Act and properly promulgated regulations.

IV.

High Volume Reviews and Systemic Failings Combine to Forge a Prescription for Disaster

The mandate of the 1980 Social Security Act Amendments to review all cases of permanent and non-permanent disabilities in a relatively short period of time, in addition to the hundreds of thousands of regular application determinations ordinarily required is simply an impossible task for any state DD agency.

The entire justification for this CDI requirement for all cases has erroneously been called a "G.A.O. study" by Commissioner Svahn. In reality it was a Social Security study which cannot be assumed to be objective and independent of bias; moreover, the reports' conclusion on ineligibility of a minority of beneficiaries never tested the numbers of supposed ineligibles against whether the initial decisions concluding they were ineligible would be upheld upon appeal. With reversals on appeal before ALJ's of sixty-seven per cent and with over half the cost succeeding in federal court, any initial findings by anyone in SSA must be highly suspect.

We urge Congress to reconsider and repeal these mandatory reviews of all cases and review a much smaller number where substantial medical improvement is both probable and can be proven to justify cessation. Specifically, the high volume of reviews has had the following effects:

1. Cursory review of the evidence. The state adjudication process can only be described as arbitrary and completely failing in due process. A recently disclosed report of the Pa. Office of Vocational Rehabilitation, for example, admitted that its DD bureau engaged in a "dehumanizing" and "frenzied" adjudication process, where the bureau could not possibly meet the demands of the 1980 Amendments. See Pa. Office of Vocational Rehabilitation, Task Force Report on Bureau of Disability Determination (Feb. 1982), filed with Subcommittee staff, and "Task Force" Disability Agency 'Not Responsive'", Philadelphia Inquirer, p. 4B (May 21, 1982), attached as Exhibit 'A'. Although the adjudication theoretically has all the prior information available, in practice the adjudicator ignores all the evidence but the most recent consultative examination, ("CE's"), the one-shot medical exam given by a

doctor who has never seen the beneficiary before and who rarely has any medical history available to him or her.

75% of the 540,000 CDI's will utilize Consultative Examinations ("CE's") as will 40% of initial determination cases, according to SSA Assoc. Comm'r Sandy Crank (Testimony of Sept. 18, 1981 before House Social Security and Oversight Subcommittees).

Consultative examinations have been made mandatory as a matter of SSA policy, even if there is enough evidence in the file to make a decision. See Program Operation Manual System (§DI 2810.4. Despite Congressional hearings last Fall, SSA has imposed no controls over the use of so-called "high volume consultative examiners"; SSA refuses to provide CE doctors with complete, prior medical histories; and appears blind to a pattern throughout the country of the most abbreviated and shoddy examinations, which in Pennsylvania, at a maximum fee of $35, produce low quality evidence yet determinative of a person's entire entitlement.

2. Ignoring of treating physician evidence. In practice treating physicians are totally excluded from the process. The high volume of cases causes adjudicators to cut corners and not seek such evidence. Thus Pa.

adjudicators told Robert Astrove, who is 60 years old and a World War II veteran, whose multiple disabilities include severe arthritis, angina, high blood pressure, diabetes, and a psychiatric nervous condition, that they would not even write to his two treating VA hospital doctors, a neuropsychiatrist and an orthopedist because as a matter of policy they could not wait for VA to respond because then they would not meet their processing time goals.

In addition, evidence more than 3 months old is not considered "current" in Pennsylvania and is deemed irrelevant, something which would shock any professional physician.

SSA always falls back on the lame excuse that the claimant must prove his disability, yet their form Cessation 1 notice gives the beneficiary as their "due process" but 10 days to obtain additional medical evidence making it virtually impossible for the beneficiary to obtain additional treating medical source evidence. Moreover, the very physical and mental disabilities of the claimant plus his dependence on over-worked Medicare and Medicaid doctors make it grievously unjust for SSA to put the burdens of proving disability this way upon the claimant during the initial review processer.

Current SSA policy in the POMS does not even mandate that treating physician evidence be fully developed and complete in the file before a CDI cessation is ordered. See SSA, Program Operation Manual System, §DI 2862(B) (July 1979), attached as Exhibit 'B'.

When treating medical sources are sought, the state DD agency almost never informs them of the type of medical information required, nor are they given copies of the Listing of Impairments. Thus initial reports from treating doctors often lack the required specificity because SSA and the DD agency hide the ball from them. When caring and conscientious doctors summarily conclude what is often obvious even to a layman, that a person is totally disabled, the state DD agency as a matter of SSA policy ignores the report as conclusory and fails to follow-up with requests for more detail. See 20 C.F.R. §404.1527.

Finally, SSA and DD agencies fail to afford to treating physician reports the binding effect and great weight our federal courts have uniformly held is required in relation to the one time consultative exam. See, e.g., Bastien v. Califano, 572 F.2d 908,912 (2d Cir. 1978); Hephner v. Mathews, 574 F.2d 359,362 (6th Cir. 1978); Allen v. Weinberger, 552 F.2d 781,786 (7th Cir. 1977); Rossi v. Califano, 602 F.2d 55,58 (3d Cir. 1979).

Because the HHS Secretary and SSA Commissioner have ignored repeated federal court decisions on the use and weight of treating medical source evidence and the clear value this evidence possesses, coming from professional experts who are most familiar with the person's medical conditions, we urge Congress to amend the Act to require full development of treating medical evidence for the immediate past year, affording it the weight it requires. We suggest an amendment to Sec. 223(d)(5) by adding:

> (8) In any case where the Secretary is conducting a continuing disability review of any individual already receiving disability benefits, the Secretary shall not make any decision terminating or suspending benefits without first obtaining complete and sufficient medical reports from all medical personnel treating the individual within 12 months of the time of review, and without the Secretary having given to these reports probative weight greater than that given to any consulting examination administered.

3. Medical Improvement Deemed Unnecessary to Prove. Up until 1976, SSA had a common sense and reasonable burden in CDI cases to show that a beneficiary had medically improved as a prerequisite to a cessation decision. This past regulatory policy, 20 C.F.R. §404.1539(a), 416.939(a)(1979), had found repeated confirmation in legislative history to various amendments to the Social

Security Act which show that Congress assumed a cessation was appropriate when the disability "may have ceased," Sec. 225 of the Act, 42 U.S.C. §425, only where there existed an improved condition. See, e.g., S. Rep. No. 96-408, 96th Cong., 1st Sess. 4 for history of 1980 Disability Insurance Amendments, Pub. L. No. 96-265, §301(a), 94 Stat. 449 ("not entitled to DI and SSI benefits after he has medically recovered"); S. Rep. No. 404, 89th Cong., 1st Sess., reprinted in (1965) U.S. Code, Cong., & Adm. News 1943, 2044 ("terminate entitlement to disability benefit in cases of recovery based on such evidence"); S. Rep. No. 1856, 86th Cong. 2d Sess. reprinted in (1960) U.S. Code, Cong. & Adm. News 3608,3703, for history to 1960 Social Security Amendments, Pub. L. No. 86-778, §403(a), 74 Stat. 969 (benefits end where "his physical or mental impairment improves to a point whereby reason of such improvement he is able to engage in substantial gainful activity").

In a typical, secretive move, SSA dropped its medical improvement policy in July 1976 belatedly getting around to announce its omission in 1980, see 45 Fed. Reg. 55566 (1980). Thus SSA set the stage to treat every single disabled beneficiary up for CDI review as merely an applicant applying for the first time -- ignoring all prior disability determinations and past medical history. Not surprisingly, then, whereas in 1975 only 16% of CDI's resulted in cessations, by 1978 the rate had grown to 50%. See Subcommittee Survey of State Disability Agencies: Adjudicative Climate, p.17 (Feb. 1, 1979), U.S. House Committee on Ways & Means, Subcommittee on Social Security, 96th Cong., 1st Sess., WMCP: 96-5.

Current SSA uniform policy establishes that "it is not necessary to show that the individual's medical condition has "improved" since the prior determination." Social Security Rulings (SSR) 81-6 (Jan. 1981) and Memorandum of Louis B. Hays, SSA Assoc. Comm'r, OHA, of Feb. 23, 1982, directing all Administrative Law Judges to ignore a Court of Appeals decision, Finnegan v. Mathews, requiring a showing of medical improvement before cessation. Attached as Exhibits 'C' and 'D' respectively.

SSA's continuing refusal to show substantial medical improvement before cessation perhaps best shows how they wish to push people off disability via assembly line processes which do not even make the most basic and sensible of inquiries: has the beneficiary improved for the better since SSA and the DD agency themselves found him to be virtually totally disabled. Mass volume reviews and the desire to save money have made SSA more insistent in defending its "we don't care if there's no medical improvement" policy. Yet our federal courts around the country have begun to demand that SSA fuffill the intent of Congress by requiring a prior showing of medical improvement in cases coming up for judicial review, See. e.g., Patti v. Schweiker, 669 F.2d 582 (9th Cir. 1982); Finnegan v. Mathews, 641 F.2d 1340 (9th Cir. 1981); Miranda v. Sec'y of HEW, 514 F.2d 996 (1st Cir. 1975); Magee v. Califano, 494 F. Supp. 162 (W.D.N.Y. 1980); Shaw v. Schweiker, ____ F. Supp. ____ (E.D. Pa. Feb. 4, 1982). Typical of SSA's posture, the Administration has ignored all these decisions requiring legal services attorneys to bring affirmative, law enforcement class actions now underway from our program in Pennsylvania, Kuehner v. Schweiker, C.A. No. 82-1839 (E.D. Pa.), in Vermont, Smith v. Harris, C.A. No. 79-244 (D.Vt.), and in Oregon, Siedlecki v. Schweiker, C.A. No. C82-61R (W.D. Wash.).

Congress should not permit SSA to continue to avoid its responsibility to prone medical improvement before cessation.

We therefore suggest amending section 223(d) to add a new subsection:

> (7) For purposes of this subsection and subsection (a)(1) above, a disability shall have ceased only when the Secretary finds that there has been a substantial medical improvement in the disability or disabilities of the individual or where newly discovered evidence shows that the original disability determination was clearly erroneous.

This is a sensible and fair means to go about reviewing beneficiaries who have already, often more than once, already passed Social Security's most stringent eligibility requirements.

4. Resolving All Doubts Against the Claimant. SSA has told state DD agencies, in effect, to treat beneficiaries as new applicants by only looking at their current medical condition. This plus the high volume of cash has led adjudicators to resolve all doubts against claimants without additional pursuit of information. Adjudicators almost never speak to beneficiaries, and as you know, never see them, to resolve doubts. State information in files is not updated. The message is clear: if there are any doubts or questions, terminate the case, and move on the next pile on the desk.

5. Ignoring of Vocational Factors and Changing the Program into a Medical Listings Program. Unlike the widow's and widower's disability programs, SSDI and SSI programs require evaluation of vocational factors when a beneficiary has an impairment which can't be said to meet or equal one of the Listings of Medical Impairments in the regulations. 20 C.F.R. §416.920(d). Thus SSA and the DD agency must review "residual functional capacity and the physical and mental demands of the work [the person] has done in the past," §416.920(e), including "age, education and past work

experience," §416.920(f).

Yet adjudicators, under pressure to turn over large numbers of cases, and we believe under clear messages from SSA in Washington to focus solely on the Medical Listings, regularly ignore vocational factors by solely comparing the recent consultative examination report with the Medical Listings and non-published interpretations of them given exclusively to DD staff, thus never appearing in the Federal Register. DD staff do not interview beneficiaries concerning ability to meet demands of hypothetical jobs, nor do they use vocational experts.

There is a most serious question whether the much touted vocational guidelines "grid", set up to streamline cases, 20 C.F.R. §404.1501 et seq., is ever used by DD staff, as many elderly disabled who would benefit from this "grid" are being regularly terminated without any reference to these regulations.

Ignoring of vocational factors not only subverts this entire legislative program but produces the following callous results. Frank Jennings, whose bone cancer and leg amputation at the hip had placed him on SSDI for 9 years was reviewed in late 1981. Despite his illiteracy and failing to complete the 2nd grade, prior job experience only as a laborer, continuing treatment for bone cancer, and lack of a usable prosthetic leg, he was informed on February 17, 1982 by the Pa. DD agency: "...you can be expected to adapt to other work." He was then terminated. Attached as Exhibit 'E' is his cessation notice and treating physician medical reports concluding he will be "impaired indefinitely."

That vocational factors and age are totally ignored is evidenced by the cessation of a 58 year old World War II veteran, Raymond Stankiewicz. Suffering from severe cervical spondylosis, degenerative joint disease, arterioschlerosis and digital artery occlusion, his latter condition was so serious that he was hospitalized in February and March 1982 for his surgery. During this period his CDI was underway. He soon was informed by mail, during his post-operative recovery, that he was no longer disabled despite two treating physician specialists corroborating his continuing disabling conditions.

Margaret Douglas, aged 57, had been on SSDI for 8 years before due to uncontrollable diabetes, severe arthritis and chronic, degenerative osteoarthrosis of the cervical spine. The state DD's own doctor, a Martin Blake, confirmed these multiple impairments and concluded she had to "restrict her activities generally." Anyone seeing her hobble up her stairs on the CBS National Evening News telecast on Saturday, May 15, 1982, had to be shocked to hear that based supposedly on the Dr. Blake report, ironically supportive of her claim, Mrs. Douglas was informed in September 1981 that she was not disabled and her benefits ceased last November 1981.

6. Ignoring of Non-Exertional, Mental Factors. The most striking victims have been those with non-exertional, mental impairments whose disabilities, one must conclude, are being ignored in a wholesale fashion. Thus, such people as Frank Kuehner, 12 years on SSDI due to a Manic-Depressive Psychosis have been terminated, with Mr. Kuehner being examined for but 10 minutes during a date consultative examination.

Frank Fisher, receiving SSDI since 1972 for chronic schizophrenia was cut off despite strong treating physician evidence confirming his severe psychosis.

Clinton Royal's schizophrenia was similarly ignored in a CDI resulting in a cessation. Since 1979 when he began receiving SSDI because of acute psychotic episodes requiring hospitalization, his condition, marked by hallucinations and convulsions, has worsened and his doctor wants to re-admit him to a mental hospital.

For Ms. M.K., the ultimate irony was that despite her severe depression, rendering her unable to work nor to maintain any personal relationships -- she has said, "the state should build gas chambers for people like me" -- she received her mid-1981 cessation while she was being hospitalized for two months in a Philadelphia psychiatric hospital.

And for Mara Park, a severely disturbed schizophrenic found walking the streets of Philadelphia with no money and no medical care, she lost her disability benefits without ever receiving a notice of the CDI review. No one in SSA or the DD agency ever considered that a personal contact was mandatory with a schizophrenic.

In sum, SSA and DD agencies have virtually amended the law to rule out psychiatric disabilities.

7. Ignoring of Pain in Adjudications.

SSA and DD agency bureaucrats have effectively anesthesized their policies, as well as their consciences, from the pain symptoms of the thousands of disabled living with daily, recurrent pain. Regulations still require consideration of pain symptoms, 20 C.F.R. §416.929, as well as do federal courts decisions in every Circuit, too legion to cite, with many holding that pain itself can be found to be a disabling condition. Yet in the last two years, the Evaluation of Pain section of the POMS, SDI 2205 (July 1979) has been eliminated with the cryptic instruction from SSA that "deletion of this section reflects the appreciation that an improper emphasis on the role of pain is conveyed." See Exhibit 'F' attached. We have not seen one case where pain was recognized in whole or in part to award benefits. Thus contrary to promulgated regulations and binding federal caselaw a lawless agency has decreed that pain is irrelevant.

Not only does this illustrate further the callous subversion of Congressional intent in this program, but also the underhanded subversion of the Administrative Procedures Act which requires notice and comment on substantive policy changes made by SSA. Through an internal, secretive change in the POMS, the disability law on pain, as well as in other areas, has become radically changed.

And now to make matters worse, in the name of uniformity of standards, the Administration is embracing H.R. 6181 (formerly H.R. 5700) Section 7 of which would require "uniform standards...applied at all levels of adjudication." Rather than creating "uniformity" in his agency by conforming to federal court decisions and the law of Congress, Commissioner Svahn thus wishes to elevate his internal POMS to the status of law to impose as binding rules on ALJ's and the Appeals Council but without subjecting the POMS to Federal Register publication and APA requirements. This is an affront to fundamental fairness for all those on Social Security and to our system of government by law, not Social Security bureaucrats.

8. Adverse Impact on the Appeals System.

SSA currently is trying to have it two ways concerning appeals: on the one hand they praise the appeals system as correcting the many horror cases published in the media, thus "adequately safeguarding individuals' rights" (Commissioner Svahn's Letter to the N.Y. Times, May 20, 1982), while at the same time scapegoating the Administrative Law Judges for reversing DD agencies 60% of the time or more, and, behind the rhetoric, trying to subvert the ALJ's through administrative and proposed legislative actions. The scapegoating will escalate because as the CDI's continue, if this Committee and Congress allow them to continue, tens of thousands of appeals will be essential above normal appeals to correct the horrible decision making going on at state agencies. Just like the messenger who brought bad news from abroad, the ALJ signaling the errors made below, will be and are now on the Administration's chopping block. Mass reviews are making appeals problems worsen:

a) Delays Will Increase. Currently it takes close to 3 months to get a reconsideration decision, most often a needless rubber stamp of the initial denial or cessation; it is up to 6 months to get an ALJ hearing scheduled; 2-3 months more for a decision; and up to 6-7 months further to get a hearing decision effectuated. Thus delays currently are at least a year before the terminated person gets a hearing, at which 60% of the CDI cessations are being reversed. It takes months more before benefits are re-commenced. This is at a time when this past year there were 175,000 ALJ dispositions. Further delays ensue for Federal Court reviews where an additional 50% and more cases are reversed or remanded.

Increased rates of appeal due to unfair cessations will greatly worsen the delay problem which currently has caused an appeals backlog of 143,000 undecided cases before ALJ's as of May 31, 1982.

b) Quality of ALJ Decisions Suffering. The increased pressures on ALJ's is decreasing their efficiency and quality of decisionmaking. Few referrals are being made for medical consultative exams and other steps required by our caselaw for ALJ's to look after the claimant's interests to develop a full evidentiary hearing record -- left incomplete by the state DD agency -- are not being pursued. The requirements of the so-called on motion Bellmon reviews of high allowance ALJ's -- but not interestingly high disallowance ones -- mean that ALJ's must write long decisions in clear-cut cases delaying the decision for months without any substantive change in result.

c) Misguided Proposals to Improve the Process. Instead of taking steps to mandate adequate development of the evidence at the state DD level, including face-to-face interviews with claimants by the DD agency, the Administration is embarking on policies to subvert the only independent adjudicators in the system:

(i) The proposal in H.R. 6181 to close the record to new evidence at the reconsideration stage, preventing ALJ's from hearing this evidence, puts impossible burdens on uncounselled claimants to obtain evidence and undermines the ALJ's salutory role to obtain, and if necessary secure the additional evidence;

(ii) An experiment, revived after public outcries killed it two years ago, to have SSA represented at the ALJ hearing will turn the hearing into an adverserial one which neither Congress nor our Courts have sanctioned or permitted;

(iii) Imposing the POMS upon the ALJ's in the name of "uniformity" is a subversive step criticized above;

(iv) Bellmon, on motion reviews solely of high allowance ALJ's is, in effect, a means to harass and intimidate ALJ's who are properly doing their sworn duty. Interestingly, the recent Bellmon report vindicated the high allowance rates of ALJ's by explaining and legitimating their decisionmaking in contrast to the shoddy quality of DD agency decisionmaking. Thus reversals were attributable to the ability to examine the claimant in person; additional medical evidence submitted to the ALJ; ALJ adherence to federal court decisions; the fact they are not bound by POMS standards more restrictive than the statute and regulations; and greater representation by claimants at this level. DHSS, SSA "Implementation of Section 304(g) of P.L. 96-265, 'Social Security Disability Amendments of 1980,' Jan. 1982 ("Bellmon Report"), at pp. 16-20, 25-27.

Congress should not allow the continuing, blatant scapegoating of the ALJ's and subversion of the only independent, fair adjudicators in the system.

9. Denials of Due Process and Administrative Fairness by Secret, Internal Decisionmaking Through POMS and "Quality Assurance" Reviews.

Due process of law has been thrust aside amidst these CDI's.

a. Denial of Benefits Pending Hearing Decision. Contrary to what is afforded those on SSI Disability or those on welfare, once a cessation decision is made, the claimant is given the right only to submit additional evidence within 10 days. Benefits then cease until an appeal decision corrects the error. In the interim, great suffering can and does take place.

SSDI does provide claimants with necessities of life, and especially if 60% or more of appeals are reversed claimants should not have to suffer during their appeal. No abuse of the SSI or welfare recipient's appeal rights to aid continued pending a hearing decision has ever been documented. The percentage of SSI disability cessations appeals is not out of proportion to those of SSDI where benefits do not continue pending the appeal.

This denial of due process also denies equal protection of the law to SSDI beneficiaries who unlike the SSI beneficiaries have long work histories of payroll deductions into the Trust Fund. The SSDI beneficiary's income and resources may even be so low as not to exceed SSI eligibility limits yet solely because of a past work history entitling them now to SSDI, they get no aid pending a hearing decision. Equal protection of the law demands they at least receive the SSI benefit level pending their appeal.

The bills sponsored by Senators Heinz, Durenberger, Cohen, Levin and Metzenbaum and others should be passed as soon as possible to provide necessary due process protections for innocent and severely disabled beneficiaries.

b. POMS = State Chamber Justice. Due process is also denied through the use and revision of the POMS to subvert the Social Security Act and regulations, and the Administrative Procedure Act. We have shown how SSA revised the POMS on pain to undermine Congressional intent and the regulations. Similarly, the POMS are more restrictive and consequently contrary to law in other areas such as standards for determining when alcoholism and drug addiction are disabling, and the listing of what are called "slight impairments," meaning non-severe conditions denied without considering vocational factors. All these standards have never been subjected to public scrutiny or comment. As an example, "slight impairment" denials went up from 8.3% of initial denials in 1975 to 25% of denials in 1977 due to these new internal, unpublished lists of "slight impairments." Use of this denial code "has been inflated by both conscious and habitual examiner actions to avoid vocational development.... The requirement that detailed vocational history and forms be obtained whenever a vocational biases code is used may have produced a tendency to avoid use of vocational information at the time of the intial disability interview." Subcommittee Survey of State Disability Agencies: Adjudicative Climate, supra, at pp. 15-16.

Other examples of abuse of the POMS can be readily provided. POMS must be made to conform to the statute and regulations and the first step is to require their publication and opportunity for comment pursuant to the Administrative Procedure Act.

c. Quality Assurance = More Star Chamber Justice. Under the benign, bureaucratic jargon of Quality Assurance Reviews, SSA has altered and imposed its policies upon state agencies without public scrutiny or knowledge by the disabled victims of these reviews. As inadequate and far removed from the beneficiary as is the DD agency, SSA utilizes a Quality Assurance or Quality Review Feedback Report system where yet a further removed, anonymous bureaucrat,whose role is never revealed to the beneficiary, makes the determinative decision in many cases, and by so doing affects the state DD adjudicator's decisions in other cases.

Joseph Borell, a 52 year old man awarded SSDI in 1978, by an ALJ, because of cancer of the bladder, is an example. Eight months after the ALJ allowance a CDI ended his benefits only to be reinstated on appeal by a second ALJ in mid-1979. Mr. Borell remained disabled due to the weakening of his abdominal wall from the surgery for cancer, with two stomal openings remaining, a large ventral hernia, and by the continuing need to have tubing drain urine from his kidneys. See Exhibit 'F' attached.

Up for yet another CDI and despite two prior ALJ awards for disability and no improvement in his condition, his case was sent to Baltimore for a Quality Review Feedback Report wherein it was concluded from SSA's Mt. Olympus that the "weakened abdominal wall" should nevertheless have permitted him to return to "less strenuous work." The report adds, "accordingly, it can only be concluded that the decisions to allowance decision." See Exhibit 'G' attached. The SSA Request for Case Action to the state DD agency while repeating the form language that the agency is not bound by the reviewer's opinions referred the reader in handwritten instructions to the above quoted Report, and its clear message, adding, "If you determine that a cessation is appropriate, please afford due process per POMS 2868 (sic)." See Exhibit 'H'. Not surprisingly, there was a state DD cessation ordered later which ignored any mention of the weak abdominal wall and hernia, or tubes draining urine 24 hours a day from Mr. Burrell's kidneys. See Exhibit 'I'. The decision did report, "Recent blood tests show that your kidney is functioning normally (sic)." Id.

It is now clear that adjudications are being directed by a totally unaccountable system of "quality" reviews which is kept secret and divorced from any direct sources of information. The claimant cannot rebut or challenge the findings or opinions of the "quality" reviewers as he is not even aware of the determinative role they play. This unjust system must be now stopped before it imposes more gratuitous suffering on beneficiaries.

10. Hardship on Claimants — SSDI provides necessities of life for most of its recipients. These unfair cessations have led to countless people suffering inadequate diets, loss of homes, and other suffering from material losses. Many states do not have welfare to fall back on and where it is available, as in Pennsylvania, it pays half or less of what is minimally needed for subsistence.

Others suffer losses with no ready measure. James McKeown, a Vietnam veteran, with over 100 operations during the course of his 10 years receiving SSDI, had among his multiple impairments depression for which he was receiving psychotherapy. When he recently received his cessation notice ending benefits to himself, his wife and three small children he had a relapse of his depression, out of anxiety as to how he would be able to care for his family.

Frank Kuehner's loss of SSDI and the Medicare coming with it, resulted in his loss of psychotherapy for his schizophrenia, greatly worsening his mental health.

And what notice, we ask, has Social Security dreamed up for the families of beneficiaries who have committed suicide after cessation of their benefits.

Steps must be immediately taken to stop these cessations and to allow for benefits to continue pending a hearing decision on appeal. Improvements in the development of the evidentiary record early in the process have already been suggested as well as forcing SSA to conform to the Social Security Act, its own published regulations and federal court decisions.

The lawlessness and inhumanity of this once beneficient agency must be drawn to an immediate close. We trust that this Committee can accomplish this speedily. Thank you for the invitation and opportunity to give this testimony.

Exhibits A to I are stored in the official committee files.

PROBLEMS WITH THE ACCELERATED CONTINUING DISABILITY INVESTIGATION PROCESS

The initial responsibility for a continuing disability investigation has been placed with the State agency. I am particularly familiar with procedures utilized by the State agency in South Carolina because I have practiced law in the State of South Carolina since 1971 and have specialized in Social Security disability matters. The current continuing disability investigation process does not resemble an objective review but instead resembles an aggressive effort by a governmental agency to terminate a percentage of Social Security disability claims. The current disability investigation process proceeds initially with a written form being furnished to the claimant. The claimant is asked to complete this form which includes certain information about work efforts, periods of hospitalization since entitlement, medical treatment since entitlement, and efforts at vocational rehabilitation since initial entitlement. This information is returned by the claimant to the State agency. The review process which begins is totally inadequate. The entire initial review process has consistently been directed toward finding some reason to terminate the payment of benefits. In many instances medical resources are never contacted by the State agency. One physician will be contacted by telephone and the telephone contact will be summarized by an official of the State agency. In many instances the questions which are presented to the claimant's physician develop a totally misleading picture concerning the claimant's health. Records of hospitalization are frequently not requested by the State agency. New medical conditions which have developed since initial entitlement are not mentioned and are not developed.

The most egregious error committed by the State agency exists when medical consultative examinations are arranged at government expense. The claimant is referred for a comprehensive medical examination by a specialist. Unfortunately, the specialist has never seen the claimant before and does not have the benefit of medical history. It is the written policy of the State agency in South Carolina to "select" those medical records that it feels are appropriate for the medical consultant to have for medical history. In many instances critical medical reports have been deleted from the medical history furnished to the examining consultant. The medical consultant will frequently reach decisions concerning the claimant's residual functional capacity that are erroneous. These decisions would have been completely different if the medical consultant had been furnished with a comprehensive medical history that is in the possession of Disability Determination officials. I genuinely believe that medical consultants are selected on the basis of their willingness to prepare reports that are favorable to the government's position for purposes of denying or terminating benefits. I also believe that this selective process of furnishing medical information to medical consultants is a deliberate effort to obtain a medical report from a consultant that will probably be more favorable to the government's effort to terminate benefits than the report would otherwise be if the consultant had comprehensive information.

In many instances the conclusions reached by disability medical consultants are ignored. Social Security disability benefits have been terminated in at least 15 separate Social Security claims when the medical consultant who examined the claimant at the request of the State agency has concluded that the claimant is severely impaired. In other words, the Disability Determination Division has moved forward with an effort to terminate benefits although the consultants have consistently stated that benefits should be continued. I can only assume that someone in the disability agency was disappointed by the report and has elected to proceed with a termination utilizing some standard unknown within the Social Security regulations. It would almost appear that some type of quota has been applied when this type of medical information has been ignored.

The Social Security Administration expended sizable amounts of energy and money in developing detailed regulations which spell out the sequential evaluation process to be utilized in Social Security disability applications. All of these regulations went into effect in February of 1979 and they apply equally to new claims as well as continuing disability investigations. The State agencies do not utilize the sequential evaluation process. The State agencies will never consider pain in a disability application although these Social Security regulations from February of 1979 compel a consideration of pain. Non-exertional factors such as mental disease, mental retardation, shortness of breath, dyspnea, nervousness, and pain apparently will not receive a valid consideration as part of a continuing disability investigation although all of these matters may have been considered in the initial award. The State agency insists on utilizing standards that are not part of the Social Security Act and that are not part of the Social Security regulations dealing with disability. As long as the State agency insists on relying on the POMS I can assure you that the disability evaluation process is always going to be unsatisfactory.

The Office of Hearings and Appeals and the administrative law judges within that agency appear to be the only individuals involved in the appeals process that correctly consider Social Security regulations and correctly consider the definition of disability contained in the Social Security Act. The administrative law judges should never be criticized for their role in correctly considering Social Security disability applications. The decisionmaking process within the State agencies should be brought into line with the correct application of Social Security regulations at the hearing level. I have detected a genuine resentment of the Office of Hearings and Appeals within State agency circles. This type of interagency bickering is unfortunate because the Office of Hearings and Appeals is correct and the State agency is consistently incorrect in considering disability applications. The State agency attempts to convert disability claims into some type of objective review or mathematical process that is totally stripped of any human consideration. It consistently ignores Social Security regulations and consistently relies on POMS and consistently makes mistakes.

I would like to make the following recommendations to improve the initial and reconsideration levels of review in new applications and in continuing disability investigations:

1. The Disability Determination Division is currently reviewing Social Security disability claims that have been favorably decided by an administrative law judge in the last two years. Any award of Social Security disability by the Appeals Council, an administrative law judge, or the United States District Court should be afforded some presumptive weight unless the decision is more than 36 months old.

2. The State agency should be compelled to obtain medical information that is complete and should be compelled to contact each medical resource listed by a claimant in the initial continuing disability investigation report. A disability payment should be undisturbed by the State agency unless there is medical information to document a medical improvement or unless there is vocational information to suggest that the claimant has undergone rehabilitation which would now allow him to perform some type of work. In the absence of a showing of medical improvement or rehabilitation the previous decision of the Social Security Administration should remain undisturbed and benefits should be paid.

3. The reconsideration process should be eliminated in Social Security continuing disability investigations. After all,

the State agency has been responsible for making a recommendation that disability benefits be terminated. For all practical purposes, a very small percentage of Social Security terminations are reversed on the reconsideration process. The reconsideration level of review has become a meaningless type of review available in continuing disability investigations when termination has been recommended. The State agency is being asked to reconsider its earlier recommended termination. The statistical information will clearly indicate that the reconsideration is a meaningless form of review in disability determinations and should be eliminated. A claimant should be entitled to an immediate hearing once the Office of Disability Operations has issued a termination notice from Baltimore, Maryland. The claimant should be notified in the termination notice of the right to request a hearing within 60 days of the termination notice. This would eliminate the need for a reconsideration process as part of the continuing disability investigative review and would also allow the claimant to have immediate access to a hearing during a period of time that he continues to receive Social Security disability benefits. This would substantially reduce the workload for the State agency, would effectively reduce the number of personnel required in the State agency for the reconsideration process, and would afford greater due process protection to Social Security disability claimants. Almost all Social Security disability hearings in this type of investigation could be conducted within 90 days after the termination notice. Benefits are currently paid for at least two months after the month of termination. Under the circumstances it would be quite likely that a Social Security disability recipient could continue with payments until a hearing has been held.

4. The Social Security Administration should insist that State agencies utilize the February 1979 sequential evaluation process which clearly defines the administrative process to be utilized in Social Security disability applications. The State agencies must discontinue the utilization of POMS. The POMS does not reflect the definition of disability correctly and leads to unnecessary appeal work within the Office of Hearings and Appeals. Nothing should be done to hamper the decisionmaking process which is currently available at the Office of Hearings and Appeals. The problem clearly lies within the State agency and the system utilized by the agency in considering disability applications in the first place and in conducting disability investigations for termination. The State agencies could very definitely obtain substantial education from reading the regulations of February 1979 and in applying those regulations consistently.

5. Finally, someone should remind the State agency that it is not administering a welfare program and that the recipients of Social Security disability benefits are human beings that deserve some measure of courtesy and civilized treatment. The attitude of local State agency officials can only be defined as shocking. Many Social Security claimants have begun to understand, from the attitude of the disability examiner, that the

review process is not going to be objective and that benefits are going to be terminated regardless of the information submitted in support of the claim.

Respectfully submitted,

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August 11, 1982

STATEMENT OF UNITED AUTO WORKERS
ON
SOCIAL SECURITY DISABILITY PROGRAM
August 18, 1982

The UAW recommends several major changes in the Administration's Continuing Disability Investigation (CDI) program which reaches Disability Insurance beneficiaries under Titles II and XVI of the Social Security Act. We speak for 1.2 million active workers and 375,000 retirees (many of whom are disabled) in the UAW who have a keen interest in the protection that Disability Insurance benefits offer.

Continuing Disability Investigations

Section 311 of the "Social Security Disability Amendments of 1980" (P.L. 96-265) required the Secretary to review every 3 years those cases where disability is not expected to be permanent. These new provisions were to have commenced on January 1, 1982. In fact, Secretary Schweiker has used administrative discretion to step up the review of these disability cases and implemented the policy in March of last year. Estimates indicate that 314,000 CDIs were processed last year, with 520,000 scheduled for 1982 and 832,000 in 1983. This represents a 350% increase in the number of cases reviewed between 1980 and 1983. Given that the number of staff at the Social Security Administration has been fairly constant and the state disability determination agencies have yet to expand their staffs, it is not surprising that there is a high level of error in the CDI program which results in wrongful denial of benefits to disabled people.

We do not oppose, in principle, the spirit of Section 311 of the 1980 amendments. The government has an obligation to conserve the trust funds and to pay disability benefits only to those who have met its rigorous proofs and who continue to be disabled. The government also has an obligation to protect the rights of disabled beneficiaries by preserving in all its administrative contact with disabled people (and all other Social Security beneficiaries) the highest regard for fair treatment and due process. The accelerated CDI program has placed the benefits of thousands of disabled people in jeopardy by challenging their continued eligibility without ever having to show a change in the person's medical condition.

The number of people harmed in this process will be substantial. The number of disabled workers currently on the OASDI rolls is about 2.8 million, with about 2.3 million others receiving benefits under the Supplemental Security Income program. Preliminary statistics show that by late October, 1981 the state agencies responsible for the initial review of these disability cases were stopping benefit payments in about half the cases. If this pattern holds, and the Administration continues its schedule for review through 1983, then more than 800,000 people could be thrown off the disability rolls. Many of those erroneously denied benefits at the state agency level will win their rightful benefits in subsequent steps of the appeals process; (currently about 3/5ths of those who appeal to the hearing level have benefits reinstated) but the loss of benefits, which constitutes the sole income of many disabled workers, will mean irrevocable harm for those individuals. Disabled workers and their families could lose their homes, their automobiles and any savings they may have had while pursuing their appeals.

The media has reported a dozen or so suicides in the last year for which the proximate cause was the denial of disability benefits through this CDI process. Suicide is the most visible sign of desperation. We are convinced that the human toll of this administrative zeal will number in tens of thousands of broken lives as disabled people are capriciously denied their rightful benefits. We therefore recommend 3 legislative solutions which would: 1) place an affirmative obligation on the Secretary to weigh current medical evidence in the CDI process and show medical recovery before denying disability benefits; (2) continue payment of benefits on appeal through the formal hearing process before an Administrative Law Judge; and (3) sharply scale back the number of reviews so that the program can be responsibly administered by available staff and disabled people can thus avoid having their lives wrecked by an erroneous decision by over-worked state agency personnel.

The Secretary's Obligation to Show Medical Improvement Before Stopping Disability Benefits

Prior to July 1, 1976, the Social Security Administration Regulations required the Secretary to show that a disabled person's medical condition had improved before they could have their benefits discontinued. Current Regulations (Section 404.1594) state that,

> "when the medical or other evidence in your file shows that your disability has ended, we will contact you and tell you that the evidence in your file shows that you are able to do substantial gainful activity..."

The Secretary is interpreting this Regulation to allow the state agencies to "retry" disability cases as if they were simply initial decisions. Claimants are thus required to totally reprove their disability. The Congress has recognized this state of affairs but has not yet drafted a legislative response to this wrong-headed interpretation of the Regulation.

Leaving this Regulation and its current interpretation in place means simply the loss of the administrative equities of a sequential process where each successive step results in a binding decision (unless reversed at a subsequent, higher step). The result is the creation of an inefficient and unfair administrative "loop" whereby state agency examiners will be able to reverse prior decisions of Administrative Law Judges (or the Appeals Council or a Federal District Court) without any change in the material facts of a case. Such an illogical, expensive and cruel standard demands a remedy from this Congress, especially in light of the fact that hundreds of thousands of disabled workers now on the rolls may be subjected to this administrative nightmare. The burden of proof in the CDI program should be squarely shifted to the Secretary to show medical improvement before Disability Insurance benefits can be terminated.

The restoration of the pre-1976 standard (in the form of legislation) is even more important now that the Administration has sharply accelerated the CDI program. The only permissible exception to such a decision rule would be in the situation where the finding of disability was clearly erroneous at the outset, and this exception would require the Secretary to detail the nature of the error.

Continued Payment of Benefits in the Appeals Process

The UAW supports legislation which would continue payment of monthly benefits to those who appeal the government's decision that they are no longer disabled. Such payments should be continued until the Administrative Law Judge returns a decision based on a full and fair and independent hearing. If the original denial at the state agency level of the process is upheld by the ALJ, then those monthly benefits continued in this way should be subject to a reasonable repayment schedule, not the heavy-handed lump sum payment obligation which the Administration is now emphasizing in the Social Security program.

Continuation of disability benefits on appeal is justified out of simple fairness to those who have already satisfied the rigorous proofs the government requires to meet the definition of disability and who are now being "re-tried"; these disabled workers have a legitimate claim for benefits until the point when they have had a chance to rebut the government's findings and have had a decision returned by an ALJ. Further, given the often lengthy delays in scheduling a hearing (largely due to the Administration's acceleration of the CDI program and the number of appeals it has generated), it is grossly unfair to disabled workers to stop benefits and leave them without income for months when they have no control over the timeliness with which their case will be handled.

Slowing the Pace of the CDI Program

The UAW supports legislation which would immediately slow the pace of reviews under the CDI program. There is simply no way that the due process rights of disabled workers can be respected in a program where the demands on staff time are increased several hundred percent with no concomitant increase in the numbers of staff at the Federal or State levels. The consequences of staff error in the CDI program will be measured in broken lives of disabled workers who are denied their rightful benefits and who do not appeal. The costs of this kind of error in human terms outweigh the dollar "savings" achieved. And since many of these disabled workers will have to seek subsistence from state and local governments for income and health care, errors in the program serve only to convert Social Security "savings" into costs for other levels of government. In addition, the high rate of ALJ reinstatement of those benefits terminated by state agencies indicates considerable error in the program at the lower levels. In this kind of situation, there is a direct cost to the Social Security system in that the eligibility review amounts to another pointless layer of administrative costs.

Congress should tie the pace of the CDI program to the abilities of the Social Security Administration to handle the workload in a responsible way, which means requiring and providing adequate time for full development of current medical evidence and guiding those disabled workers affected through the process. Administrative efficiency and the rights of disabled workers are both served by slowing the CDI program.

Related Issues in the Social Security Disability Program

Many in Congress have been preoccupied in recent years with the fact that an increasing number of people have been awarded benefits at the third step of the appeals process. Other things being equal, it is not surprising to find a different pattern of decisions at the hearing level because it is a "de novo" procedure, not bound by the record to date. The ALJs are required to weigh all of the evidence, including evidence of a medical condition which may worsen during the appeals process. The fact that ALJs base decisions on a more-comprehensive evidentiary record and are bound to follow court rulings and Regulations of the Secretary means that their decisions can be expected to differ from those of the first two levels of the process at the state agency, where the examiners are also bound by internal standards (The Program Operations Manual System - POMS) developed by the Secretary without the opportunity for public notice and comment. The explanation for the increasing numbers of awards at the third step will be discussed below, but a few comments should be made first about Congressional efforts to alter the role of the Hearing stage of the appeals process.

The UAW is firmly opposed to provisions of legislation pending in the House of Representatives (H.R. 6181) which would limit the disabled worker's right to a full and fair hearing before an Administrative Law Judge. We recognize that the Senate is not now acting on a similar bill, but wish to register our objections to two of the provisions of the House bill which are very much a part of the general debate over Social Security disability.

One provision (Section 5) would close the evidentiary record for disability determinations at the second step of the process (reconsideration at the state agency). Currently, the evidentiary record is closed after the third step of the process (the hearing before an Administrative Law Judge). Most claimants are not familiar with the appeals procedures and are not represented by attorneys until the third step where objective medical evidence, opinion testimony etc. are presented. Decisions at reconsideration use the same standards as at the first step (which are in part, developed by the Secretary without public comment) and apply them to the paper evidence on file. We see no justification for narrowing the scope of evidence to be considered at the hearing level of the process where, unlike the situation at the reconsideration step, the Administrative Law Judge is bound to weigh all the evidence in light of Social Security Regulations, Rulings and authoritative court decisions.

Another provision of the House bill (Section 7) would grant the Secretary power to set uniform standards for disability determinations which would bind decision makers at each step of the appeals process. We are strongly opposed to the type of uniformity which would apply standards to any level of the decision-making process without first submitting them for public review and comment. We read the language of Section 7 as allowing precisely the kind of mechanical consistency which would contravene the whole purpose of the Disability Insurance program and routinely deny disabled workers their rightful benefits. The UAW is primarily interested in the fairness of the entire adjudicative process which leads to disability determinations.

A look at the recent program statistics on the appeals process leads us to a different remedy for any lack of uniformity in the decision-making process. In 1974, the first 2 steps of the process accounted for 95.3% of all new awards made to disabled workers (ALJs accounted for 4.2%). In 1978, the first 2 steps accounted for 85.2% of the awards and in 1979 the share had dropped to 82.8%. By 1980 the state agencies' share of all Disability Insurance awards had dropped to 78.9% and ALJs were accounting for 20.6% of all new awards. The number of initial applicants remained fairly stable (or declining) in this period but the ALJ caseload has more than tripled from 51,900 in 1974 to 172,470 as more and more people are appealing denials at the second step, which confirm earlier denials almost as a matter of course. The problem appears to be not in the third step hearing level of the appeals process, but in an inordinate number of denials at the first two steps of the procedure at the state agency levels. Thus, an attempt to make the whole process more uniform could begin by requiring the first two steps to follow uniform federal guidelines developed as Social Security Regulations and open to public comment and criticism.

The Unmet Needs of Disabled Americans

We question whether or not the entire CDI process deserves the attention and resources devoted to it by this Administration.

Social Security program statistics already show that the disability determination standards have been tightened. Estimates in 1980 indicate an absolute and relative drop in the number of Disability Insurance awards since 1975. In that year there were 592,049 awards (a rate of 7.1 awards per 1000 insured workers); recent estimates show 390,000 awards for 1980 (a rate of 4.1 awards per 1000 insured workers). The number of awards in 1980 was lower than in any year since 1970, and the rate per 1000 insured workers was lower than in any year since 1964. This 42% reduction in the rate of disability awards in a 5-year period is clearly indicative of tightened eligibility standards, implemented without any change in the statutory definition of disability.

This preoccupation with the further tightening of the standards for disability determination completely misses the crying need for greater (not less) protection for disabled workers. A recent Social Security Administration study firmly underscores the need for broadening the eligibility standards in order to meet the needs of the disabled. This study involved a survey questionnaire using a sample population from the 1970 Decennial Census to estimate the extent of disability in America. The results indicated there were 7,378,000 "severely disabled" adults in the country who were not institutionalized.# However, only one-third of all "severely disabled" adults received OASDI benefits. Thus, about 5 million disabled adults were living and dying in 1972 without monthly Disability Insurance benefits — an appalling statistic. Most severely disabled adults do not receive OASDI cash benefits and the important health care benefits DI beneficiaries qualify for under Medicare after 24 months.

Another Social Security Administration study sheds more light on the treatment of those who are "truly disabled" in America. This study tracked those who were denied Disability Insurance benefits and described their situation five years after denial. Almost 85% of those denied DI benefits in 1967 had incomes under $3600 five years later. Two-thirds of those denied DI benefits in 1967 had no earnings whatsover in 1972! What happened to these disabled workers? Seventeen percent died in the 5-year period following denial. Twenty-eight percent retired under OASI and 23% later qualified for DI benefits, leaving 32% who were alive and without earnings or benefits in the same period of time. Clearly, the rate of erroneous denials in the disability determination process is high when measured against the continuing needs of disabled Americans. Rather than a further tightening of the standards for disability determination (as contemplated in H.R. 6181), the evidence strongly suggests that a broadening of the standards is desperatey needed. Otherwise, tens of thousands of disabled Americans will continue to be assigned lives of abject poverty and pain.

# "Disability Survey 72: Disabled and Non-Disabled Adults." Social Security Administration (April, 1981), p. 318, Table K. "Severely disabled" was defined as "unable to work altogether of unable to work regularly," (see Appendix A, p. 326).

Summary

The Continuing Disability Investigation program has severe deficiencies which have resulted in much pain and suffering for tens of thousands of people already thrown off the disability rolls. Given the Administration's plans to further accelerate the program, the incidence of arbitrary termination of benefits and resulting hardships for disabled workers will become a staggering social problem. As with so many other mindless budget-cutting initiatives from this Administration, the result will be to aggravate social problems, while shifting responsibility for them to the private sector or to state and local governments. In many cases this will mean a net increase in costs to the society as once self-sufficient Disability Insurance beneficiaries are forced back into costly institutional care.

Three legislative changes in the CDI program are urgently needed: 1) the entire CDI process needs to be overhauled by requiring the Secretary to weigh current medical evidence and to show medical improvement in a CDI case (as prior to 1976) before ending a person's Disability Insurance benefits, 2) payment of monthly benefits should continue while disabled workers appeal the state agency decision through the formal hearing process, and 3) the scheduled number of CDIs should be sharply scaled back so that the program can be responsibly administered by available staff and with a high regard for the due process rights of disabled workers.

The Administration's preoccupation with purging the disability rolls has turned into a heavy-handed and arbitrary CDI program which has caused much pain, suffering and death. The process needs to be overhauled as described above, but Congress should also not lose sight of the larger issues in our disability programs. The evidence to date indicates that Social Security disability programs already reach too few disabled Americans. Yet, two Administrations have obviously tightened their interpretations of the statutory definition of disability. The reasons for this contraction of disability protection should be explored fully by Congress. The Social Security Administration owes the Congress an explanation of this trend and Congress will have to decide whether or not the Administration is fulfilling its mission to serve the needs of totally and permanently disabled workers.

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